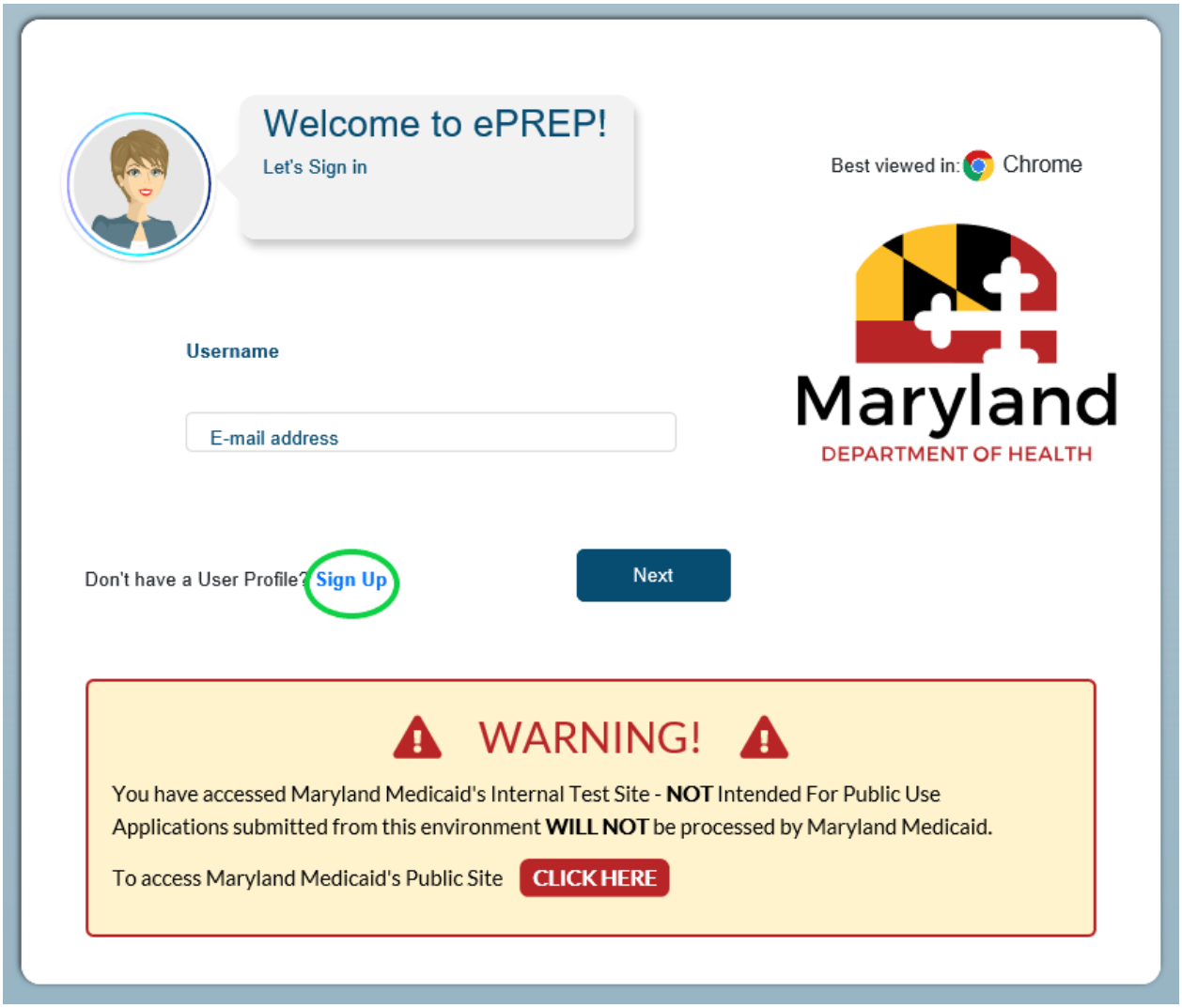
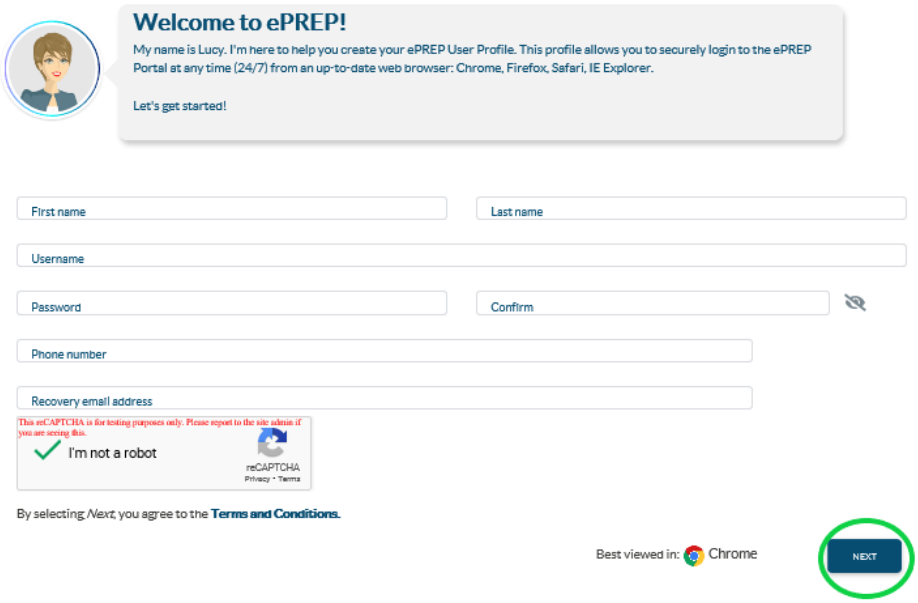
Welcome to the e PREP provider portal page!

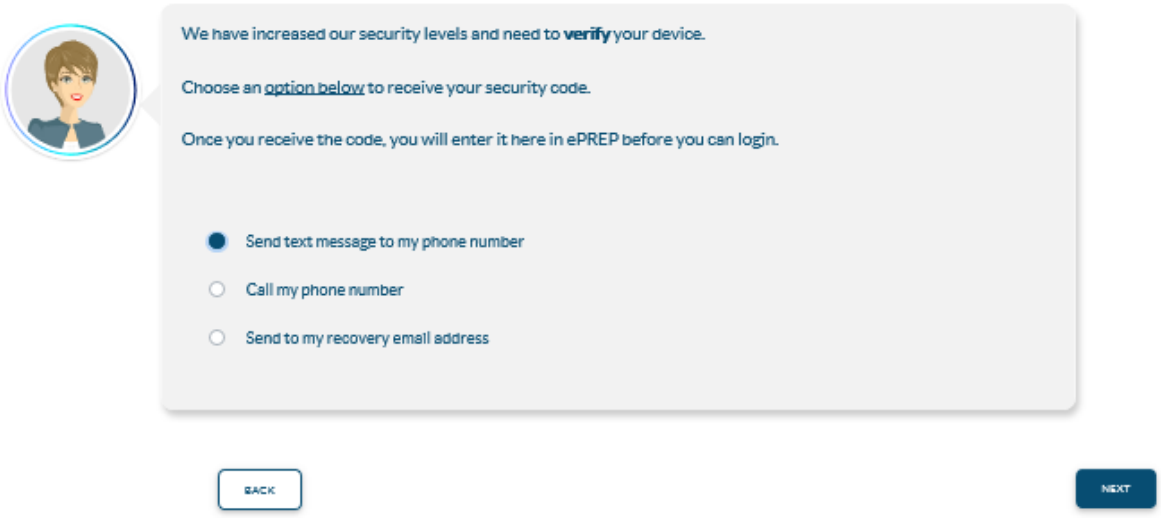
1. New providers / groups enrolling with Maryland Medicaid for the first time will need to create a user profile. In order to begin this process, please click the “Sign Up” hyperlink shown below:



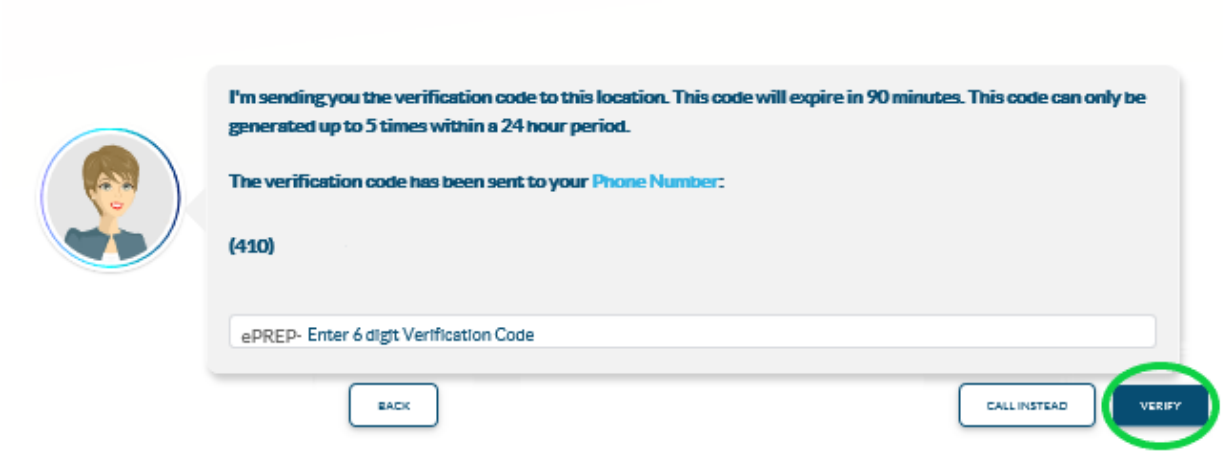
2. On this page, you will enter your personal information (first and last name), create a username, password and fill in all corresponding information followed by selecting the “Next” button when completed.

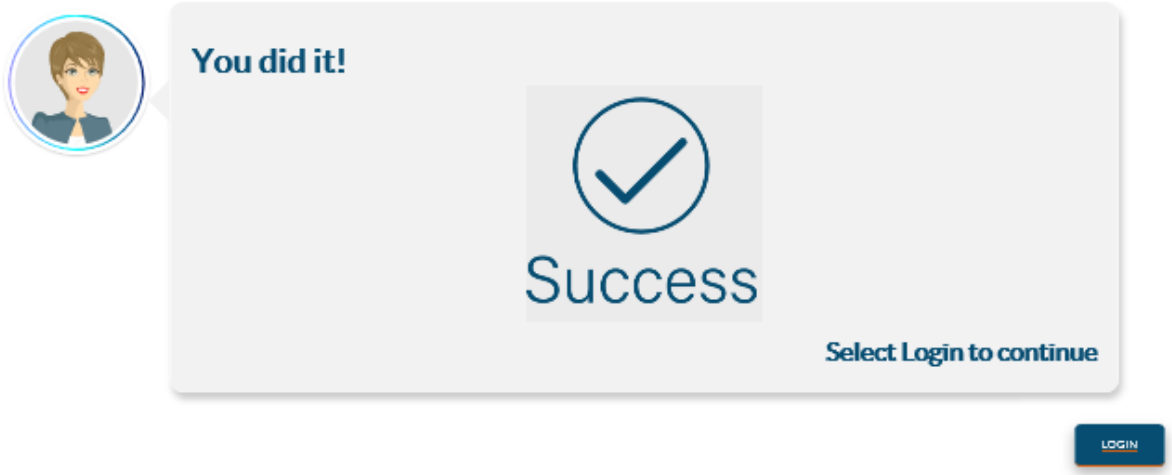


3. In an attempt to increase security measures within the portal, please determine how you would like to receive your authentication code - once you have made your selection, please click 'Next'.

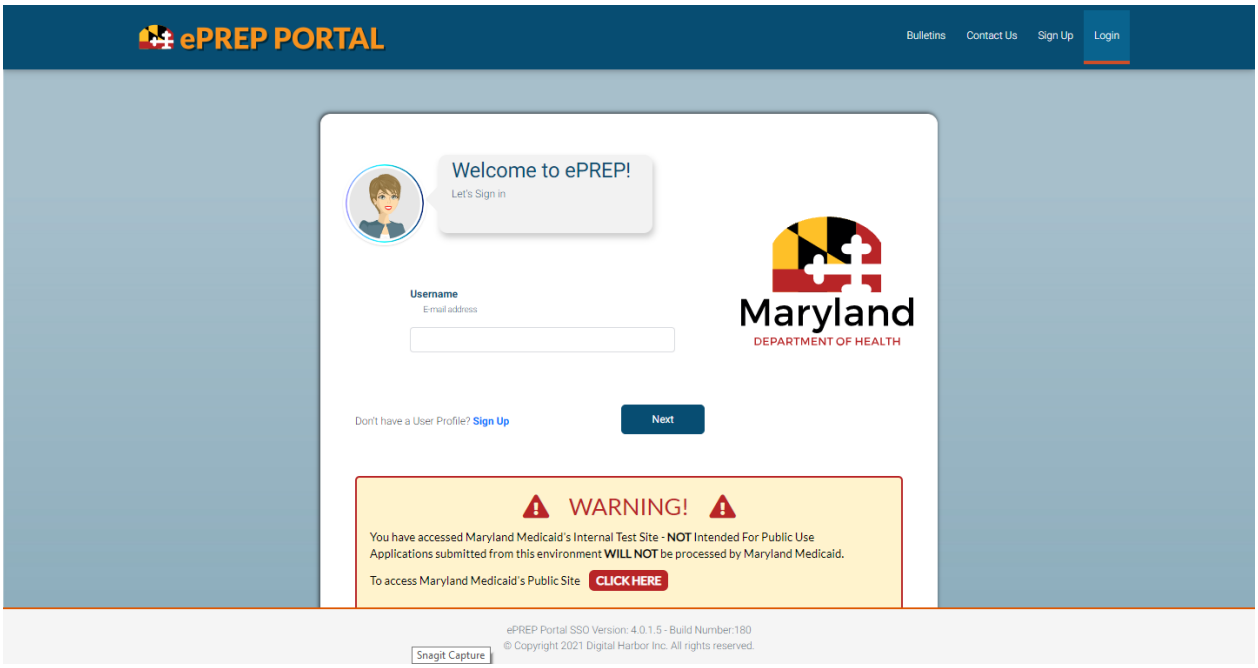


4. Please enter your 6 digit authentication code and click 'Verify'.

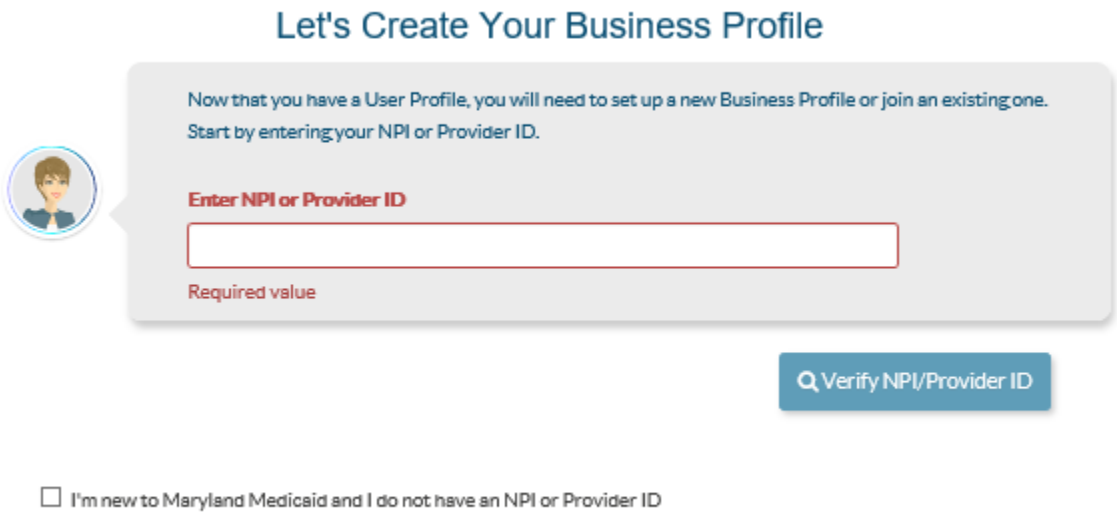




5. Once you have successfully entered and verified your security code, users will need to login for the first time with your username (email address) and password. Both of which were entered and created in the steps above.

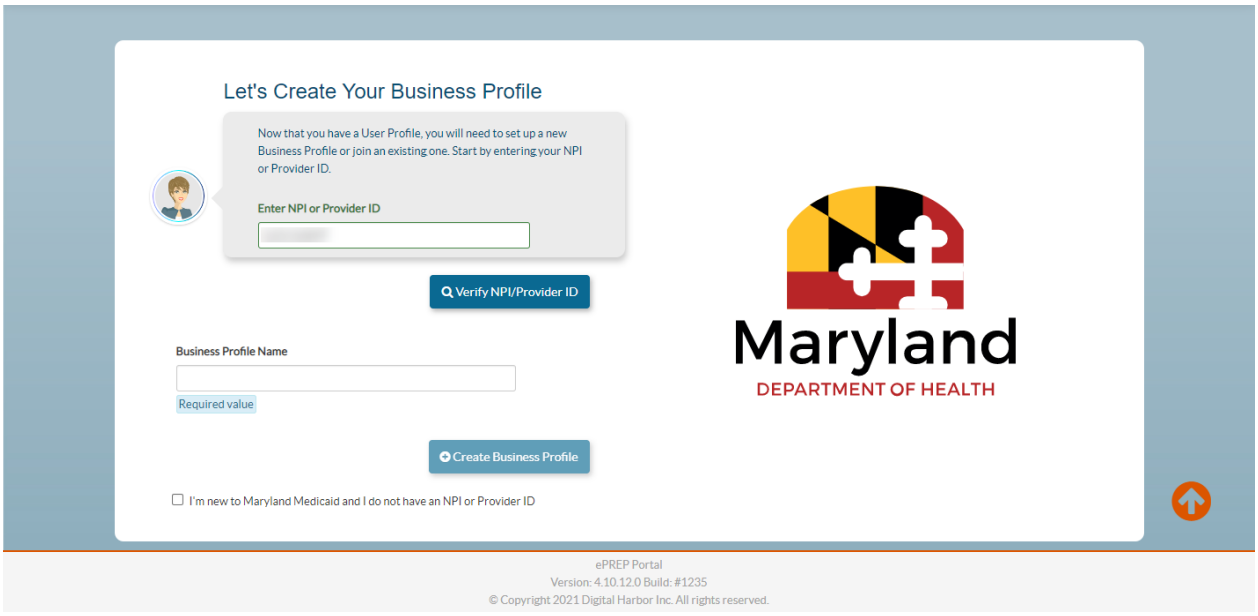


6. Once you have entered your credentials, you will be asked to create your business profile. In order to do this, you must first enter and verify your NPI number.

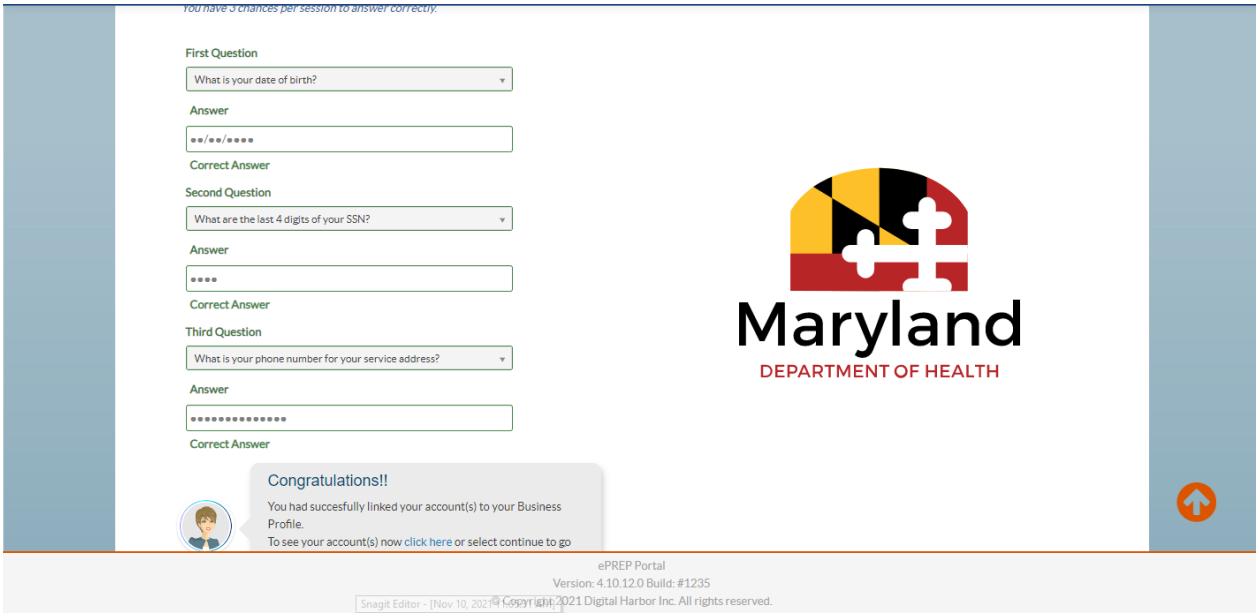


7. Once you have entered and verified your NPI, the provider ID box will turn green and you will be able to enter the provider / group name you are attempting to enroll

This is the name that will be listed on your provider business profile.



8. Security questions portion: please select and correctly answer three corresponding security questions as they pertain to your business. Once you have completed this portion, you will be able to continue moving forward through the business profile creation process by selecting “Next”.



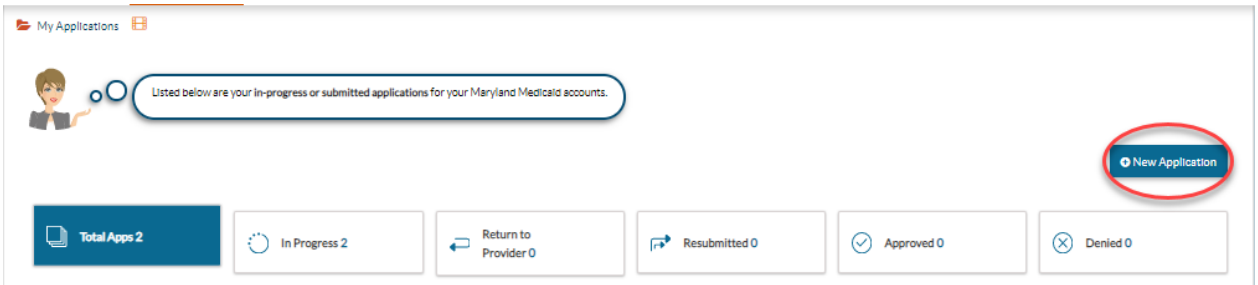
****It’s important to note that sometimes these security questions are bypassed and are able to be completed later in the enrollment process****

9. Once your business profile has been created, you will be taken to the e PREP home page

shown below:

10. From here, please click the “My Applications” tab / or building with the “My Applications” heading attached shown above.

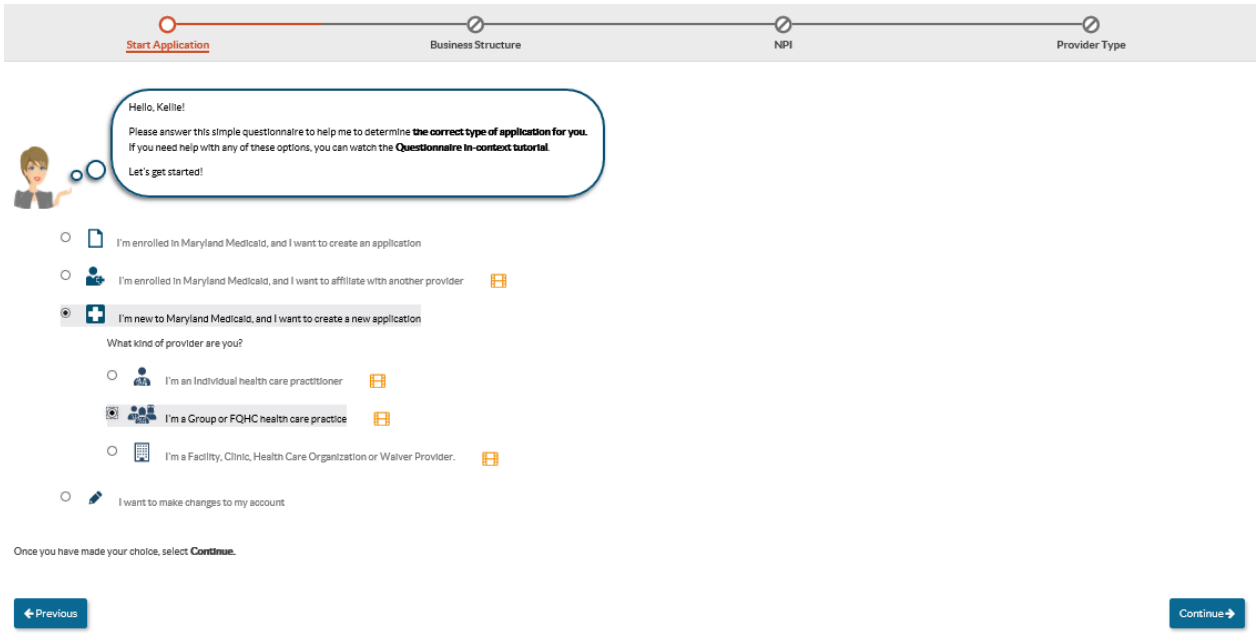
11. Once you have successfully entered the “My Applications” tab, you will need to create a new application in order to enroll your provider type with Maryland Medicaid. **Circled in the screenshot below.**



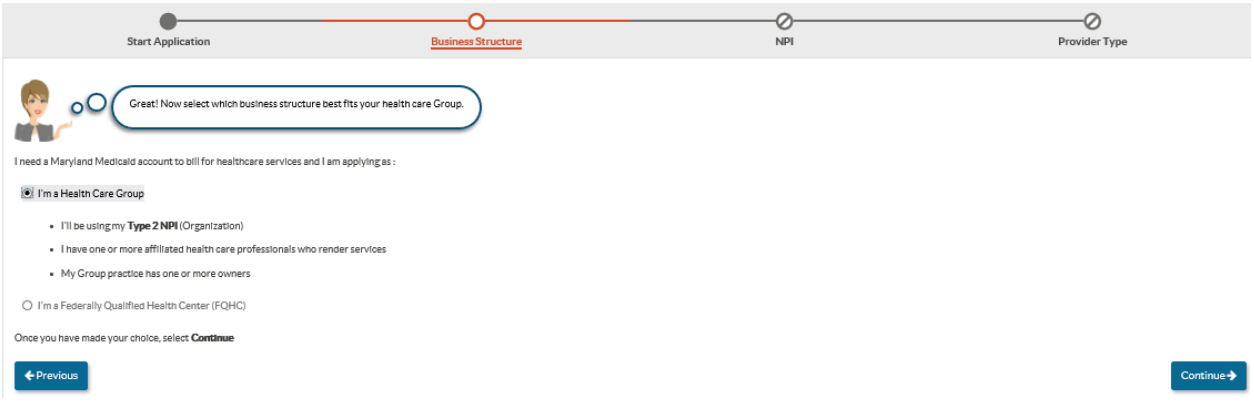
12. Application generation: once you have clicked the “New Application” tab, the following selection will need to take place in order to generate your enrollment application.

13. **Application generation selection**: please make the selections listed below:

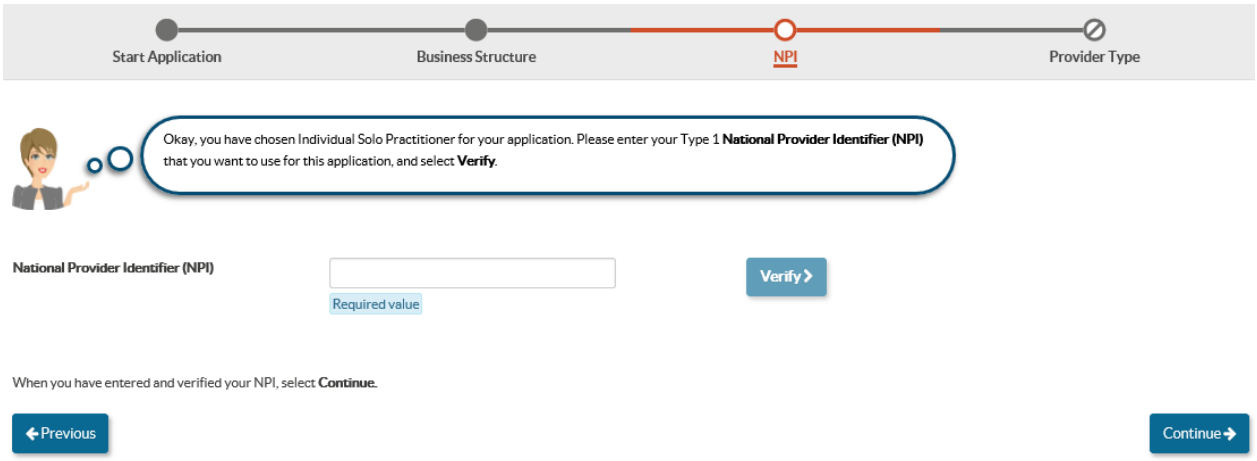
- I'm new to Maryland Medicaid, and I want to create a new application
- I'm a group or FQHC health care practice
- Continue



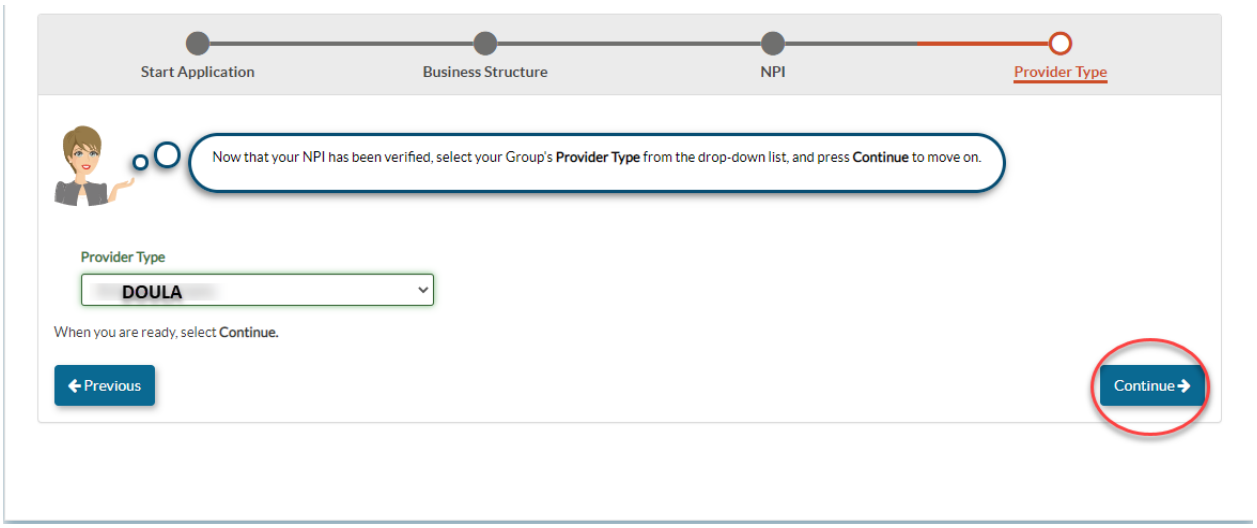
- Please select the Health Care Group option. Once selected, please select continue.



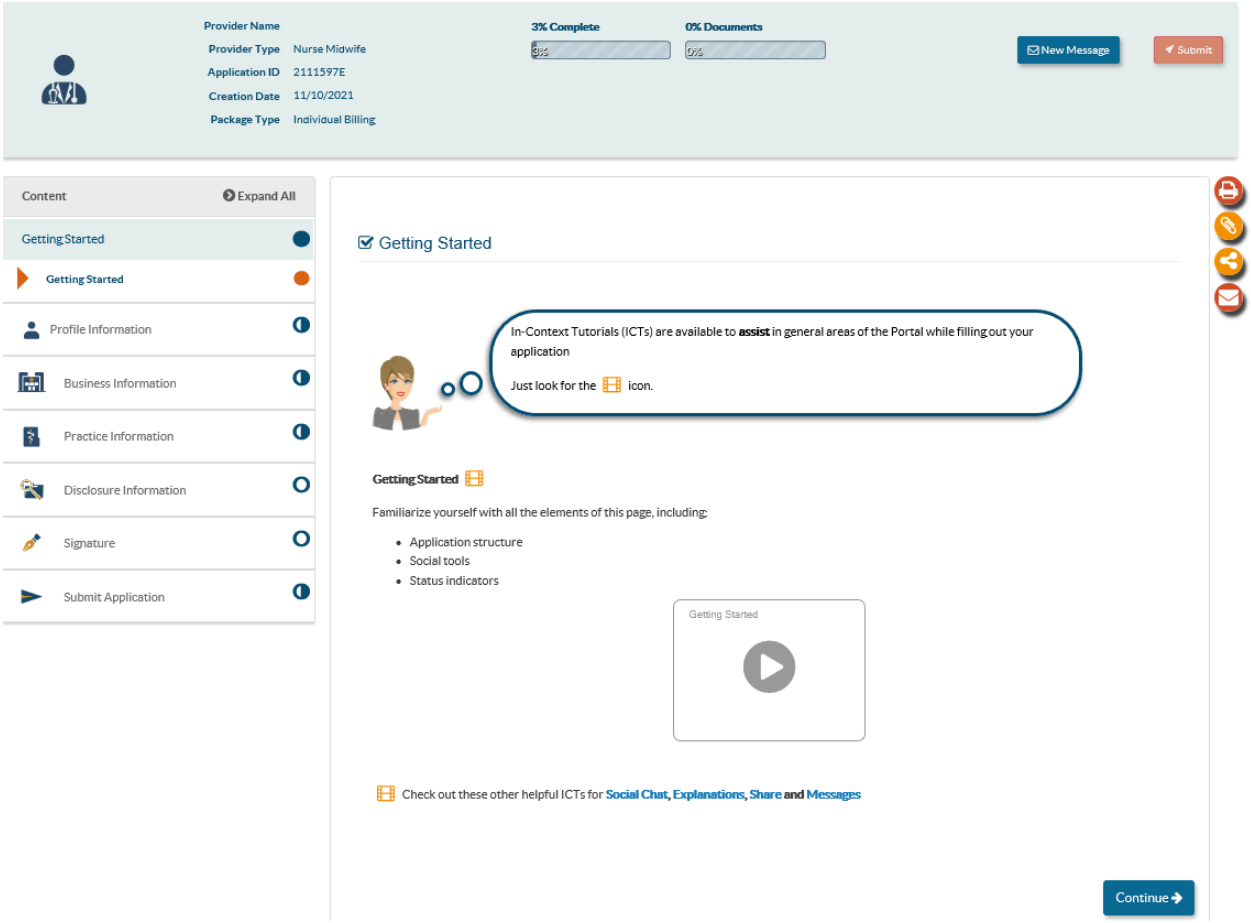
- Once you have entered your NPI, please click the “verify” option. Once the NPI has been verified, the NPI box will turn green and you will be able to successfully continue through the application generation process.



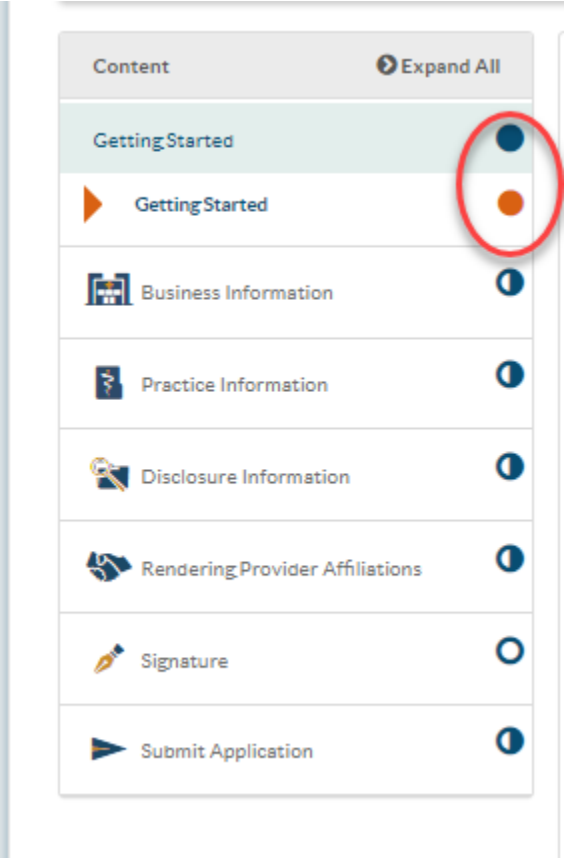
- **Provider type** - in the drop down box menu, please select the provider type **Doula** and click continue.



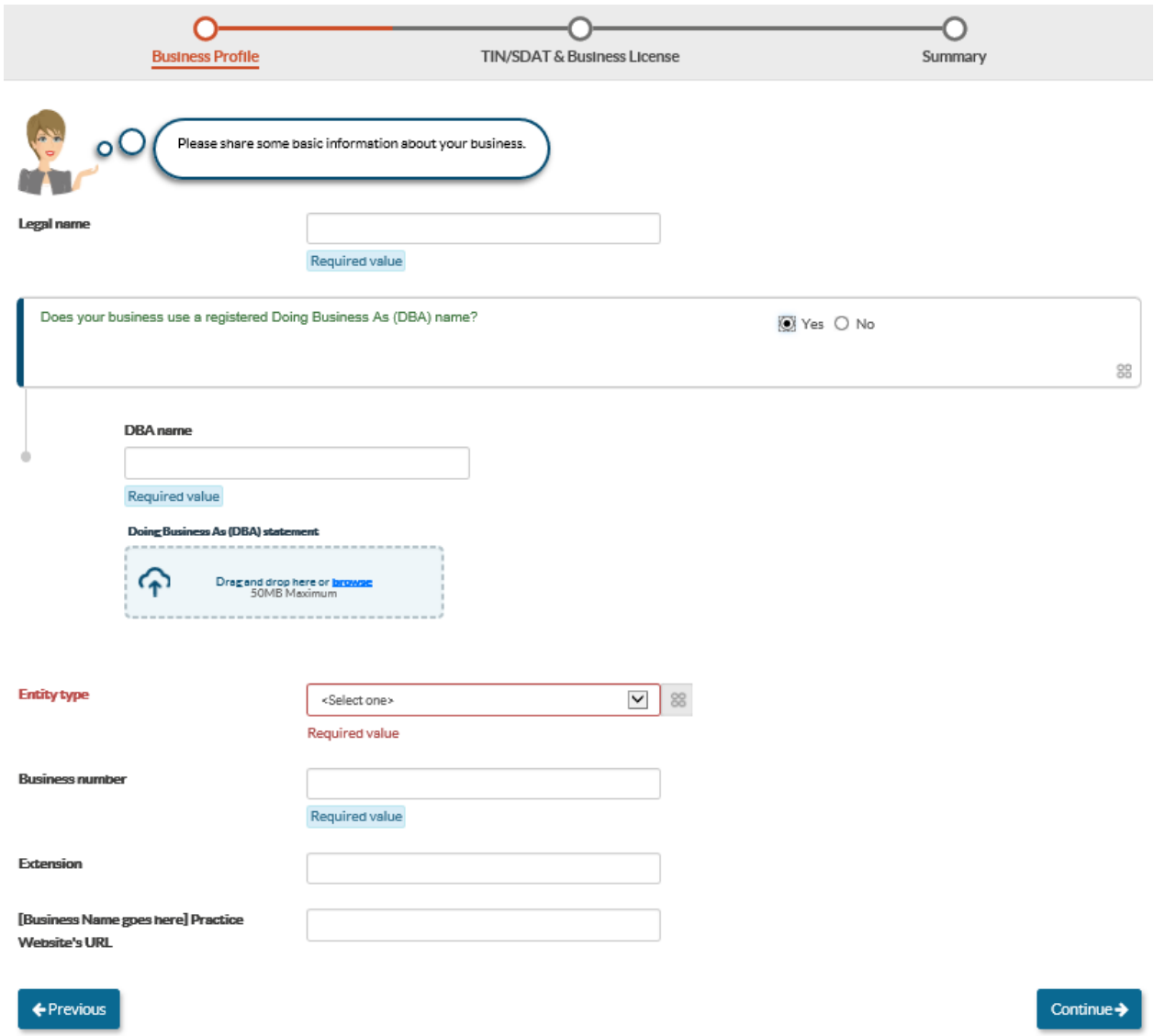
- Successful Application Generation - Once you have generated the application, you will be able to complete each required section from start to submission.



14. As you navigate the application, this side bar will indicate your progress. A fully shaded circle denotes a finished section, while a half shaded circle signifies an incomplete section.



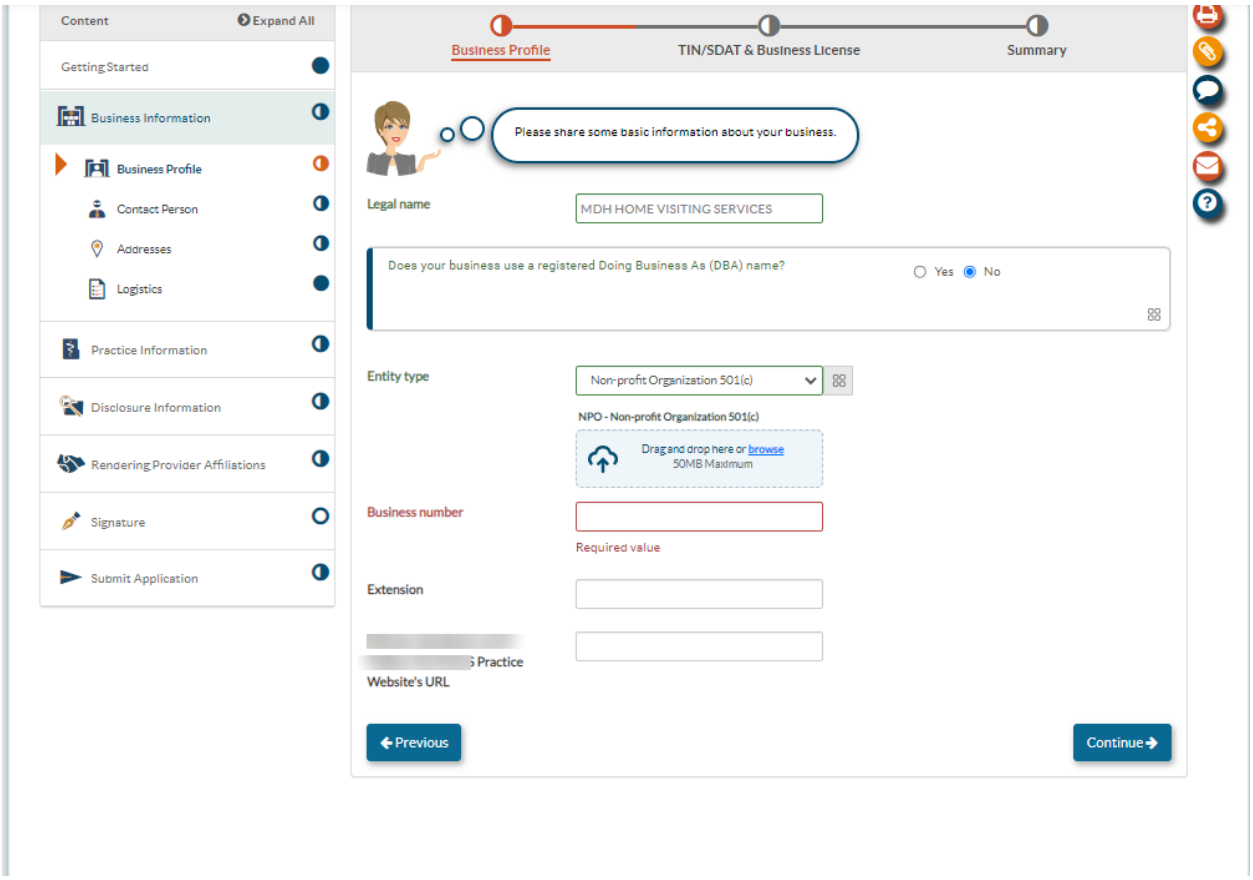
15. **Business Information:**



16. Please enter the business' legal name.

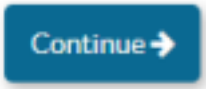
17. If you have a DBA name, please select "Yes", and attach the supporting documentation. If you do not have a DBA, please select "No" and click continue.

18. For Entity type, please choose the entity that best fits your organization. Please be prepared to upload all supporting documentation for this choice ex: Non-profit Organization requires a 501(c) be attached to the application.

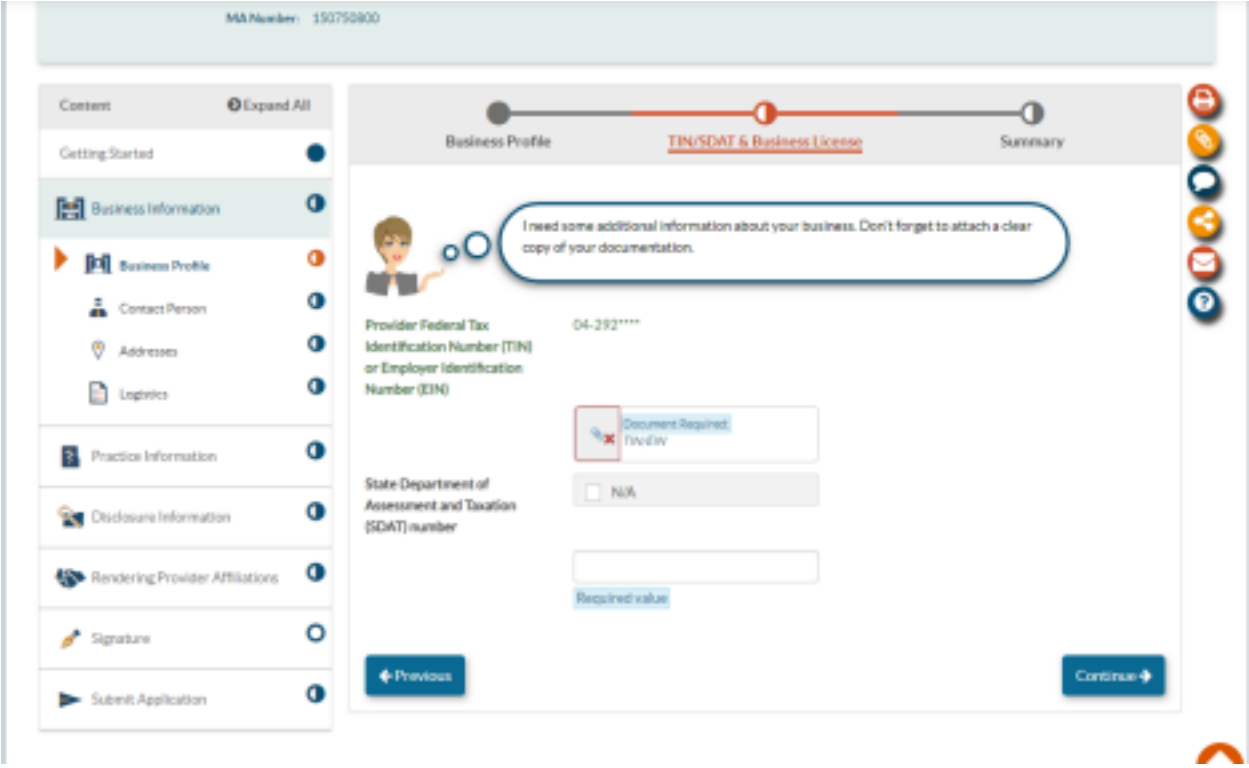


19. Enter the business number.

20. Please click continue



21. This is theTIN/SDAT Business License page. Please click on theTIN/EIN paperclip. Please upload the Tax ID Letter for your group.



22. Please click on the ‘Select your file’ button to upload the TIN/EIN document and name your document in the ‘Document Name’ box.

Example of TIN/EIN Letter:

IRS DEPARTMENT OF THE TREASURY
INTERNAL REVENUE SERVICE
[redacted]

Date of this notice: [redacted]

Employer Identification Number:
[redacted]

Form: [redacted]

Number of this notice: [redacted]

[redacted]

For assistance you may call us at:
1-800-829-4933

IF YOU WRITE, ATTACH THE
STUB AT THE END OF THIS NOTICE.

WE ASSIGNED YOU AN EMPLOYER IDENTIFICATION NUMBER

Thank you for applying for an Employer Identification Number (EIN). We assigned you EIN [redacted]. This EIN will identify you, your business accounts, tax returns, and documents, even if you have no employees. Please keep this notice in your permanent records.

When filing tax documents, payments, and related correspondence, it is very important that you use your EIN and complete name and address exactly as shown above. Any variation may cause a delay in processing, result in incorrect information in your account, or even cause you to be assigned more than one EIN. If the information is not correct as shown above, please make the correction using the attached tear off stub and return it to us.

To obtain tax forms and publications, including those referenced in this notice, visit our Web site at www.irs.gov. If you do not have access to the Internet, call 1-800-829-3676 (TTY/TDD 1-800-829-4059) or visit your local IRS office.

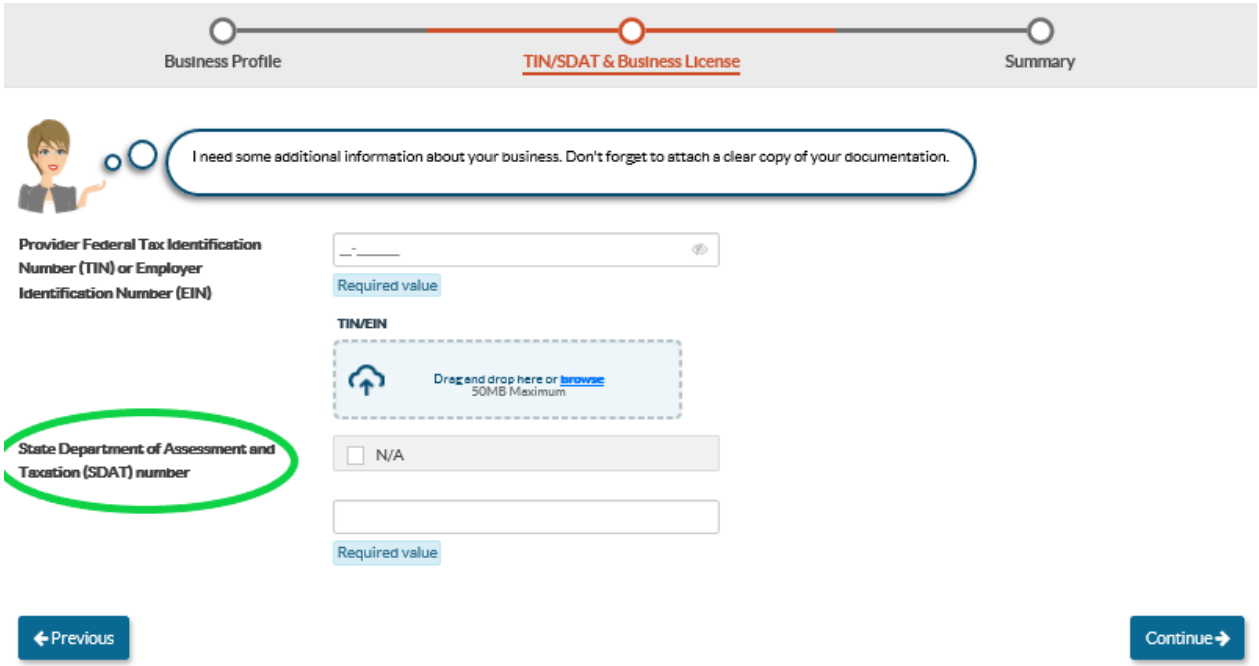
IMPORTANT REMINDERS:

* Keep a copy of this notice in your permanent records. **This notice is issued only one time and the IRS will not be able to generate a duplicate copy for you.** You may give a copy of this document to anyone asking for proof of your EIN.
* Use this EIN and your name exactly as they appear at the top of this notice on all your federal tax forms.
* Refer to this EIN on your tax-related correspondence and documents.

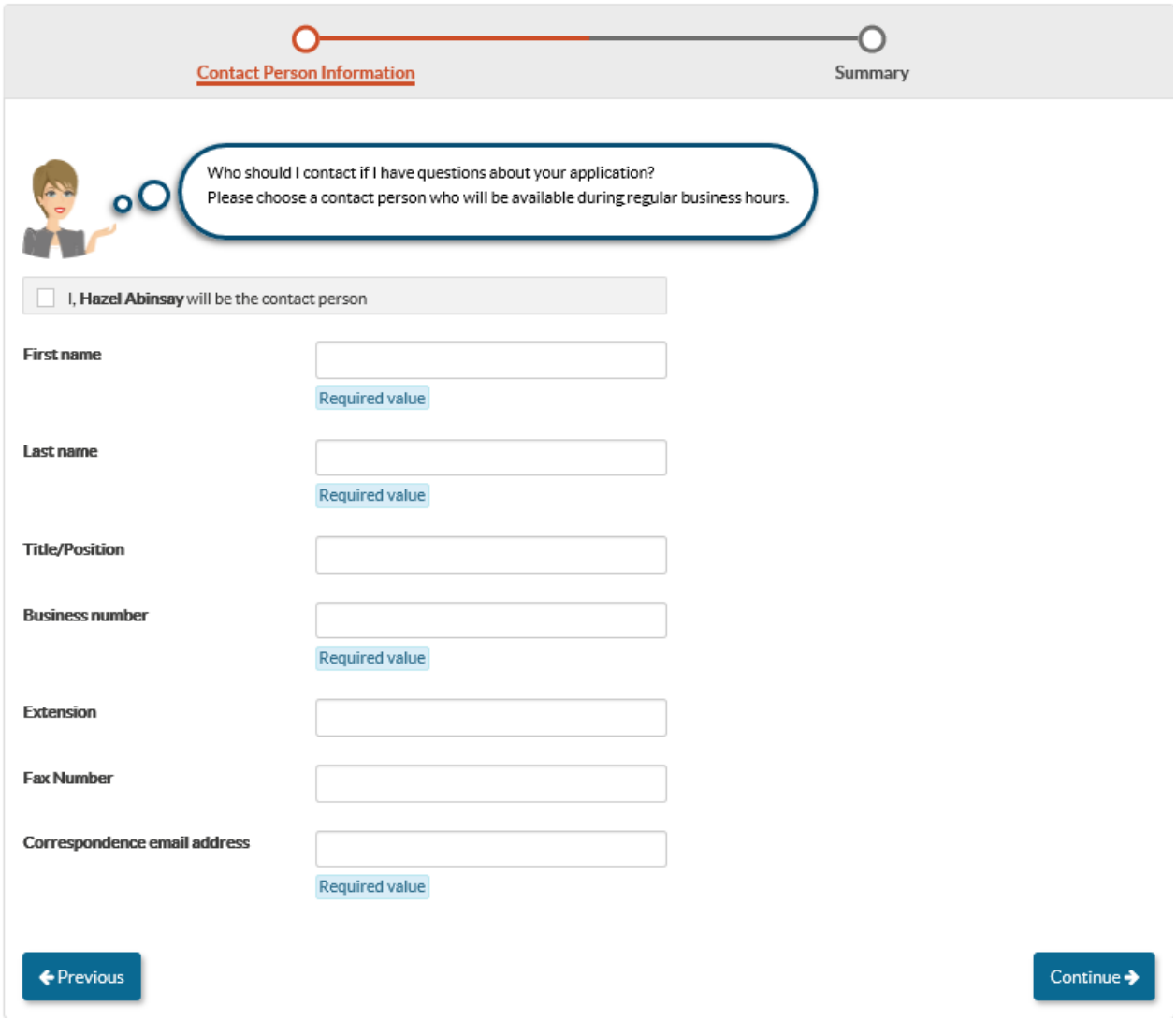
If you have questions about your EIN, you can call us at the phone number or write to us at the address shown at the top of this notice. If you write, please tear off the stub at the bottom of this notice and send it along with your letter. If you do not need to write us, do not complete and return the stub.

Your name control associated with this EIN is CAME. You will need to provide this information, along with your EIN, if you file your returns electronically.

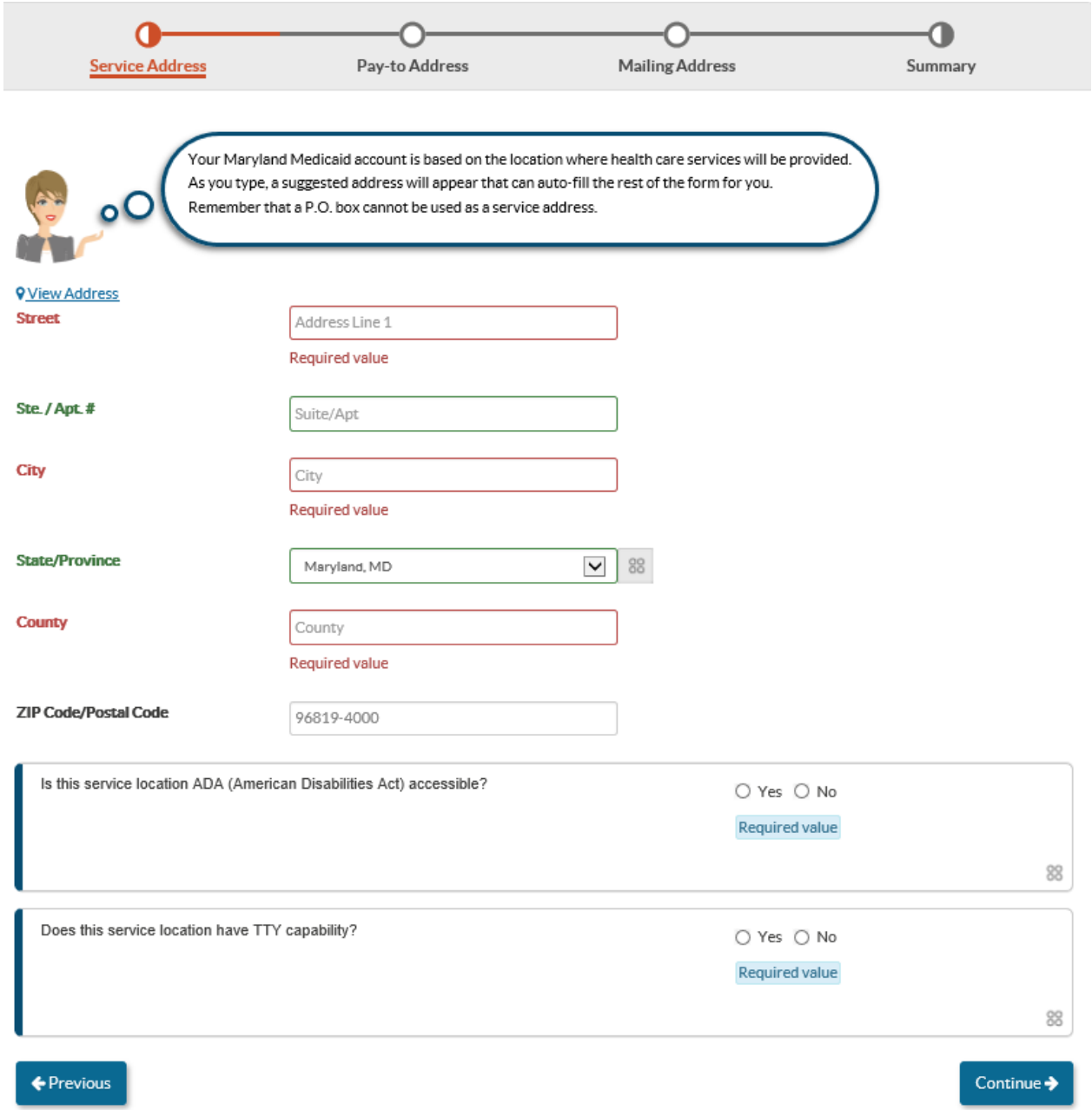
Thank you for your cooperation.



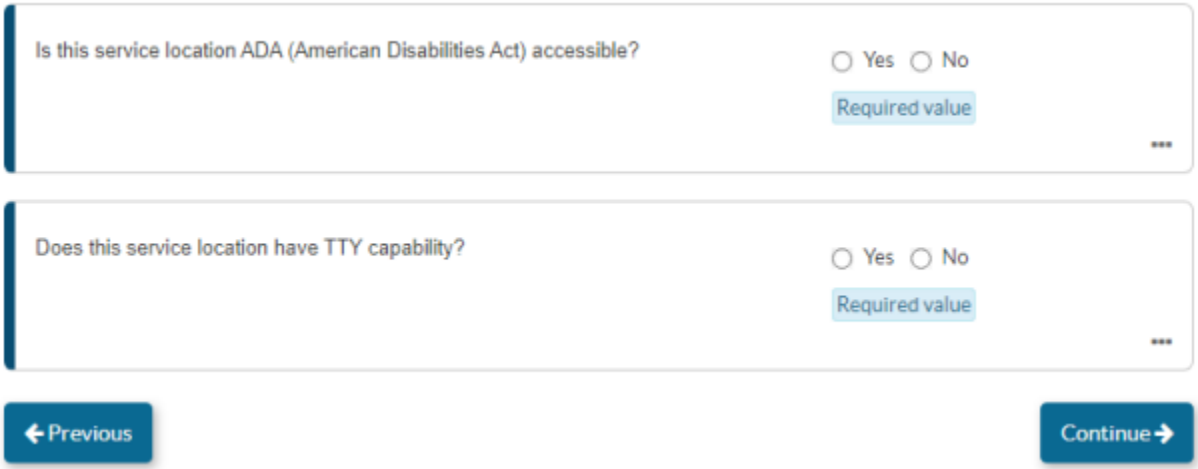
23. For the State department of Assessment and Taxation (SDAT) number, please enter your business SDAT number.
    - Providers are required to obtain and disclose their SDAT number on all applications that request it. Please do not check ‘N/A’.



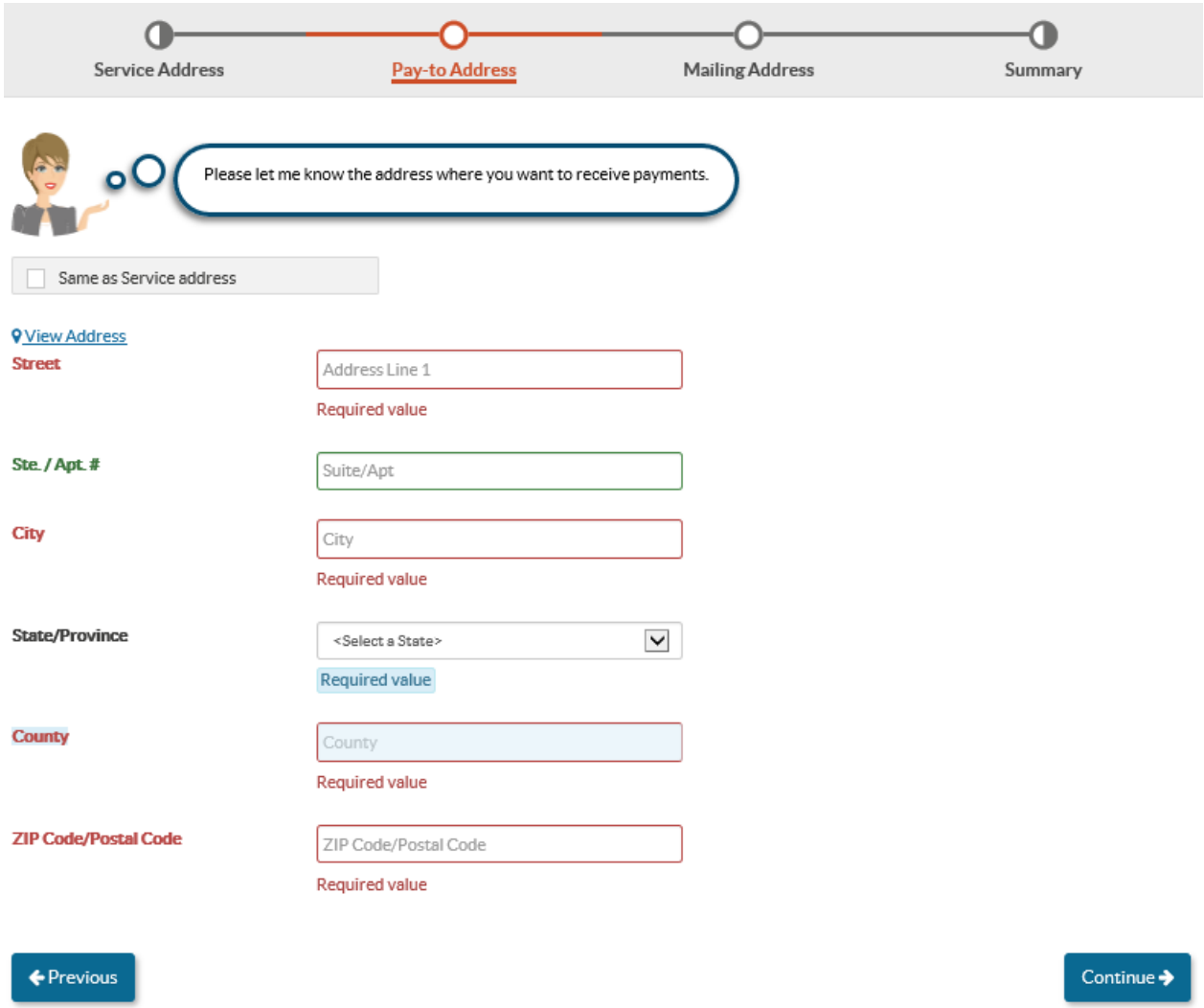
24. This is the Contact Person Information Page. Please be sure to fill out the contact information correctly. **The contact person should be the managing employee of the application. If there are any questions regarding the application, this person will be the direct contact person.**



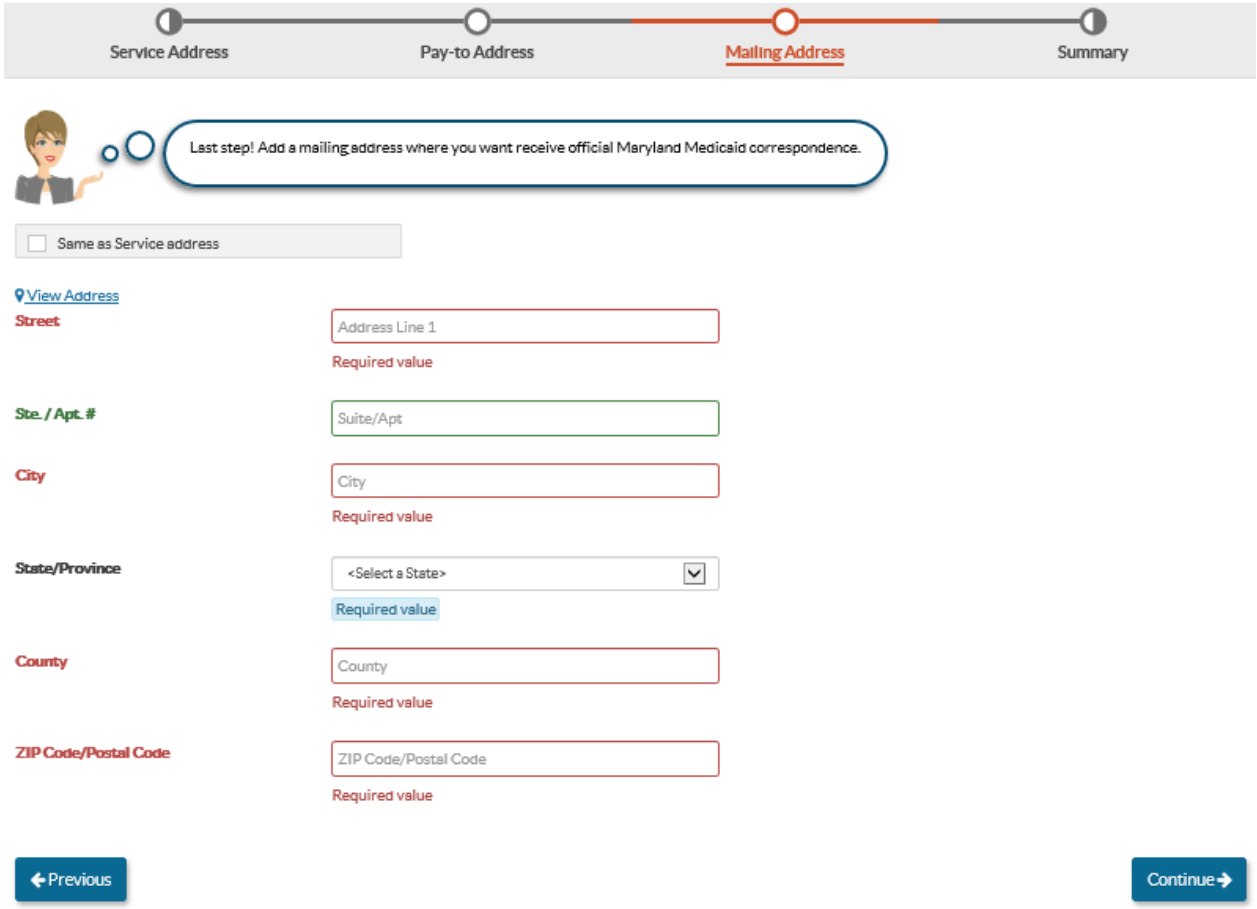
25. Please fill out the service address.



26. Please answer the following yes or no questions



27. Please fill out the Pay to Address of the location. (If you are not registered for EFT, this is the address the payment will be sent to.)



28. Please fill out the Mailing Address for the location. **If there is a specific person that needs correspondence, please identify them in the Ste./Apt.#. Please say ATTN:LAST NAME, FIRST NAME**

29. Please answer the following yes or no questions.

30. What are the business hours for this business location?
    a. If you are open 24/7, please check the box.
        b. If you are a business that has specific hours of operation, please list them here.

What are the business hours for this service location?

- ○ Open 24/7
- ○ Open on specific business days/hours

Required value

31. Has the staff of (Organization) completed cultural competency training? Please answer ‘yes’ or ‘no’.

Has completed a cultural competence training?

○ Yes ○ No

Required value

32. Is (Organization) accepting new patients? Please answer ‘yes’ or ‘no’ as it pertains to your business.

Is accepting new patients?

○ Yes ○ No

Required value

33. What is the age range of the patients that will be treated at this service location?

What is the age range of the patients that will be treated at this service location?

○ Enter age range ○ All ages

Required value

34. Does (Organization) see fee-for-services (FFS) Medicaid participants?
Please answer ‘yes’ or ‘no’ as it pertains to your organization.

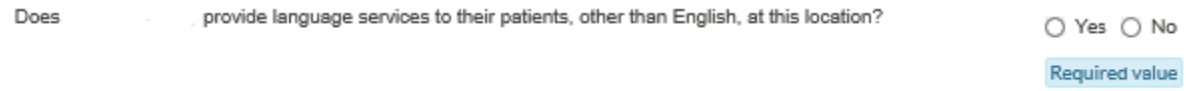
Does see fee-for-service (FFS) Medicaid participants?

- ○ Yes
- ○ No, I only accept HealthChoice managed care patients

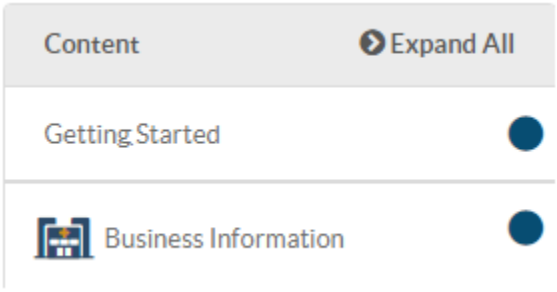
Required value

35. Does (Organization) provide language services to their patients, other than English, at this location?

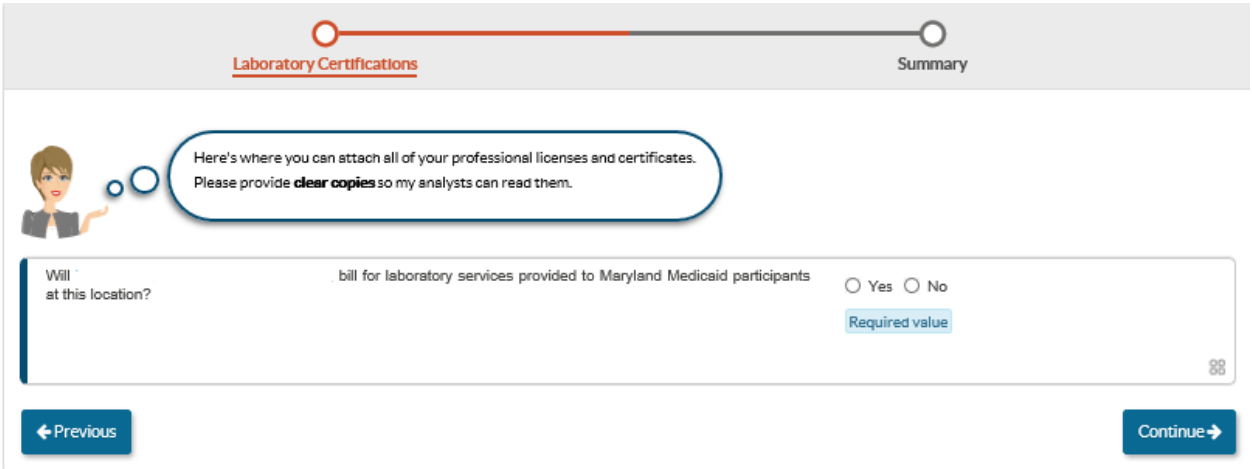
a.If “yes,” please list all other languages in this section.



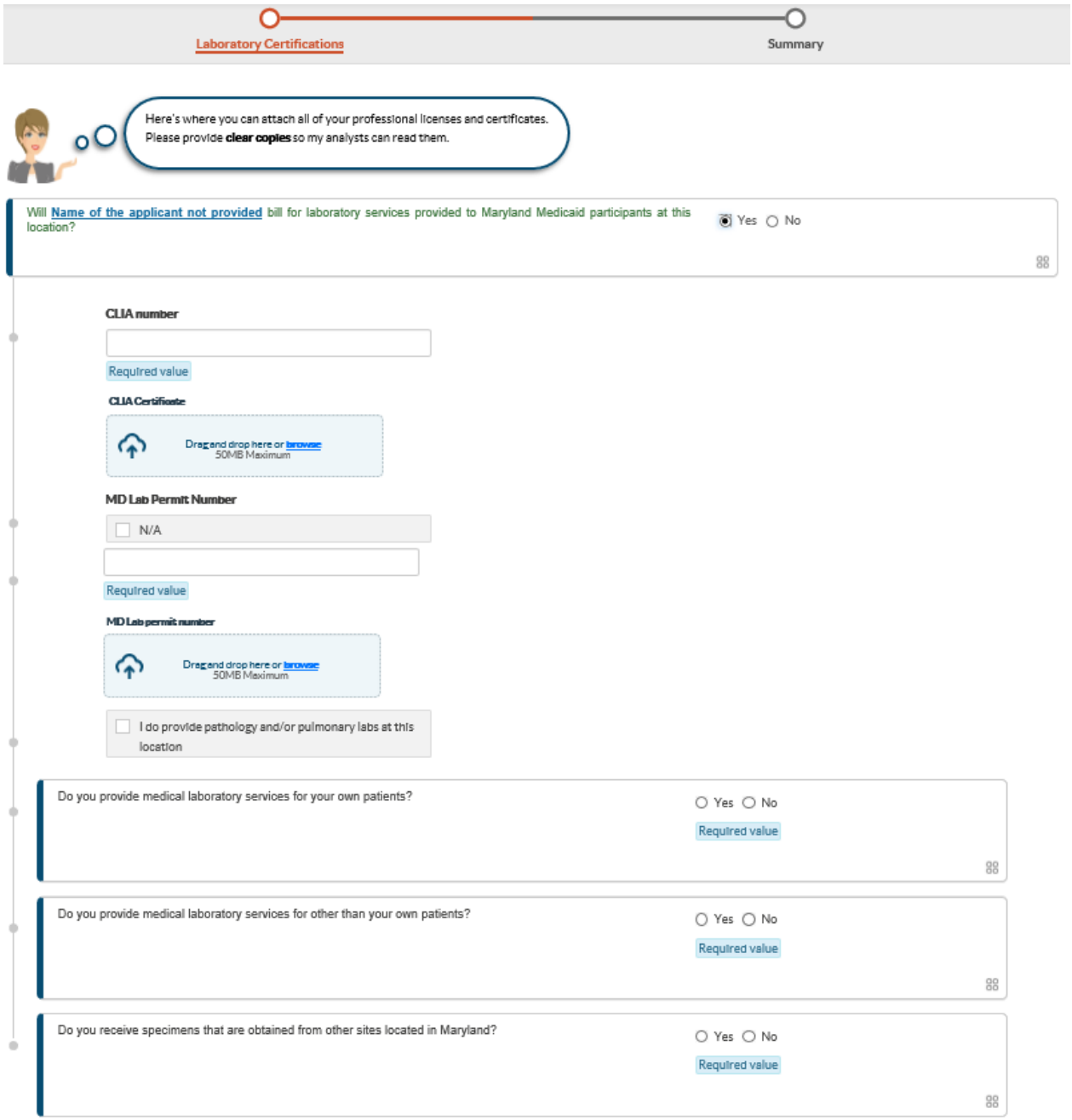
36. Once you have completed filling out all of the Business Information, the circle will be completely filled in.



37. **Practice Information Section:**



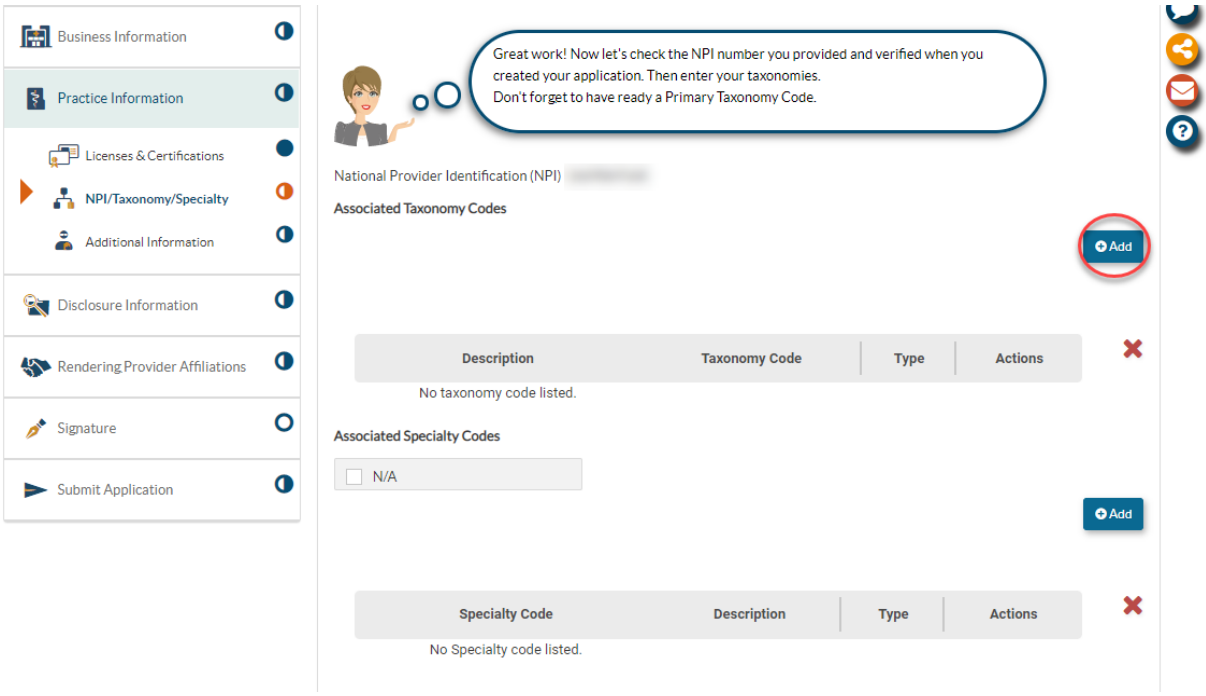
- Please answer yes or no to the question above.



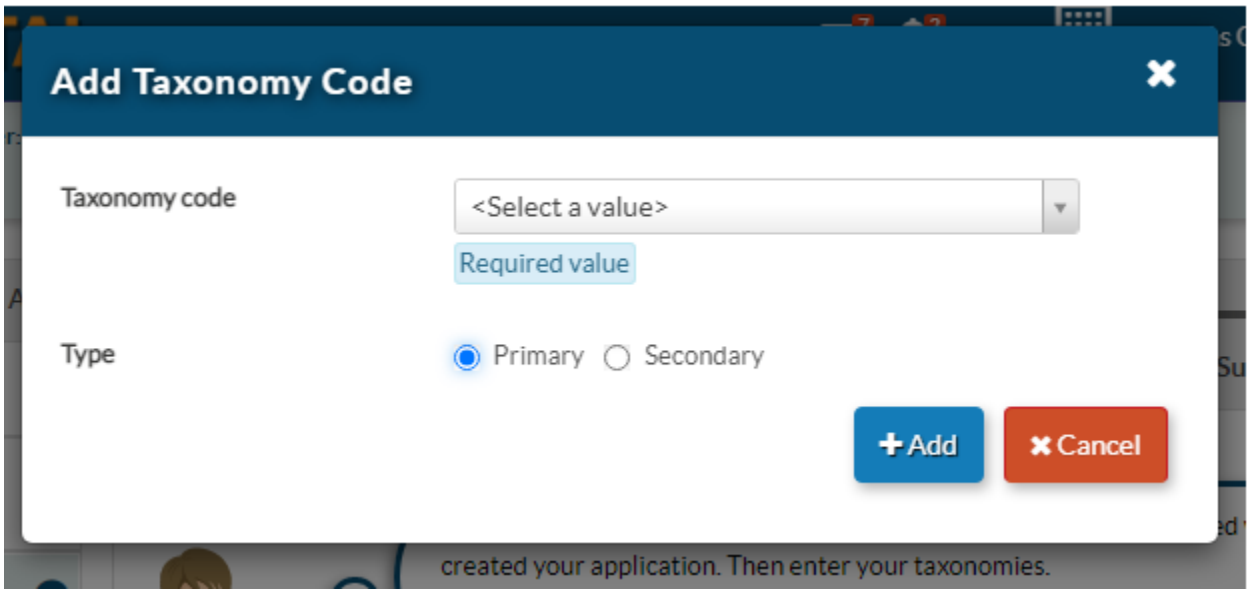
- If yes, please provide the document numbers and upload the appropriate certificates for the business' CLIA and MD Lab permit in this section.
- Please answer 'yes' or 'no' to the three questions that follow.

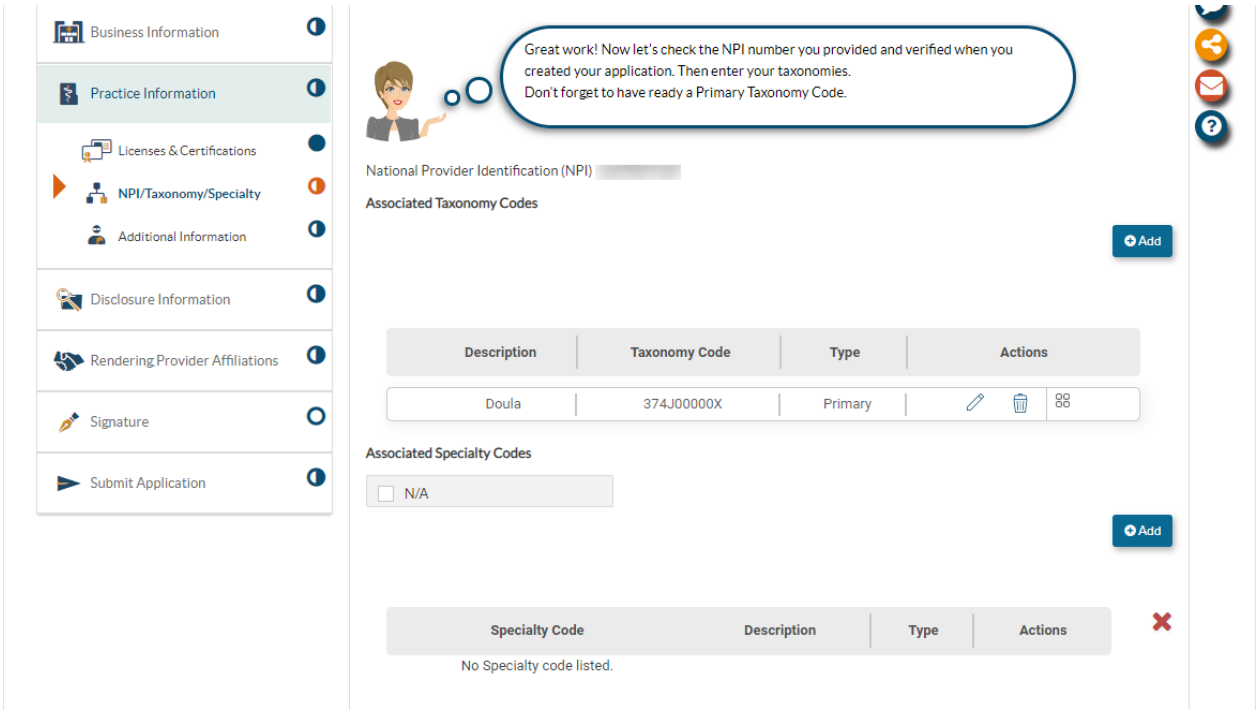
38. This is the NPI/ Taxonomy/ Specialty page. Please double check that the NPI listed on this page is correct.

a. Taxonomy code should match what is in NPPES
b. If the organization has any additional specialty codes, please list them here.

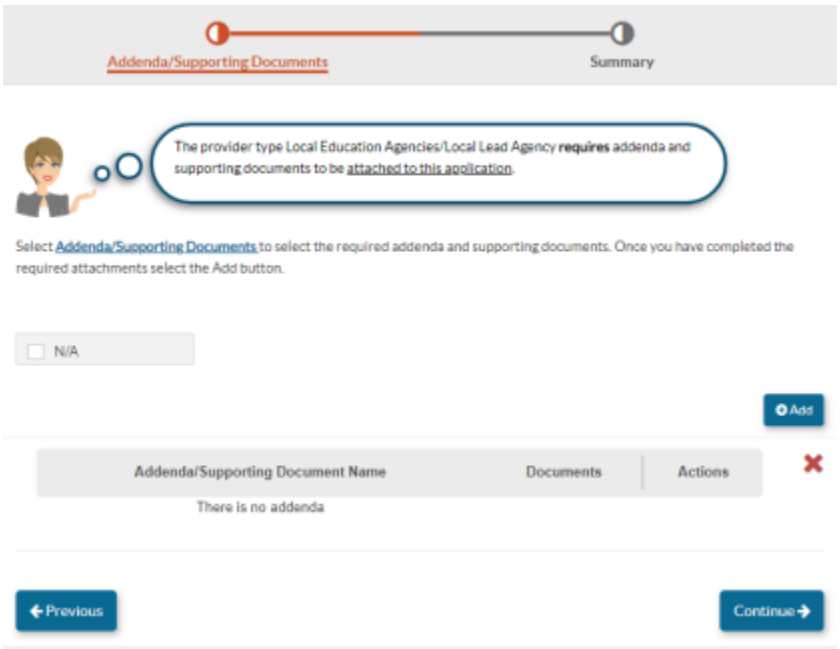


39. Please list the associated taxonomy code. This taxonomy code is listed in NPPES and was given to you when you first registered for the NPI.





40. This is the Addenda/ Supporting Documents page. Please be sure to attach the 'Medical Assistance Program Application Facility / Organization: **PT DL**: **Doula** is the correct addenda needing to be attached to this section of the application.



You can find the needed Addendum by going to the Maryland Medicaid website or by clicking on the following link and downloading the Addendum:

https://health.maryland.gov/mmcp/Pages/Provider-Enrollment.aspx

Addendum Example:

MARYLAND
Department of Health

Addendum for Maryland Medical Assistance Program Application PROVIDER

Doula/Birth worker - PT DL

If you have questions, please contact the Provider Enrollment Helpline at **1-844-4MD-PROV (1-844-463-7768)**
Monday – Friday from **7am – 7pm.**

All providers are required to use the electronic Provider Revalidation and Enrollment Portal, or ePREP (eprep.health.maryland.gov) for enrollment, information updates, provider affiliations and revalidations.

Group Doula Attestation Form. Please fill out the information below and upload the completed addendum to the "Additional Information" section under "Practice Information" within the ePREP (eprep.health.maryland.gov) "Applications" tab, along with any additional documents requested within the addendum.

Date of Attestation Submission: __/__/____

Attestation of Certification [Check all certifying organizations that you accept from your doulas in order to provide services]

- ❑ Ancient Song Doula Services
  - o Full Spectrum Labor & Postpartum Certification
- ❑ Childbirth International (CBI)
  - o Birth Doula Certification
  - o Postpartum Doula Certifications
- ❑ The Childbirth and Postpartum Professional Association (CAPPA):
  - o Certified Labor Doula
  - o Certified Postpartum Doula
  - o Certified Community Lactation Educator Certification
- ❑ Doulas of North America (DONA)
  - o Birth Doula Certification
  - o Postpartum Doula Certification
- ❑ Doula Trainings International:
  - o Full Spectrum Doula Certification
  - o OR (Birth Doula Certification and Postpartum Doula Certification)
- ❑ The International Black Doula Institute (IBDI):
  - o Pregnancy & Childbirth Doula Certification,
  - o Postpartum & Newborn Certification
  - o Lactation/Breastfeeding Certificate of Completion
- ❑ International Childbirth Education Association (ICEA)
  - o Birth Doula Certification
  - o Postpartum Doula Certification
- ❑ Mamatoto Village
  - o Community Birth Worker Certification
- ❑ MaternityWise:
  - o Labor Doula Certification
  - o Postpartum Doula Certification

MARYLAND
Department of Health

Addendum for Maryland
Medical Assistance Program Application
PROVIDER

Doula/Birth worker - PT DL

Attestation of Doula Program Certification [Check all that apply]

- ❑ The **organization** attests that all employed doulas have successfully obtained one of the certifications checked above, and have exhibited the competencies necessary to deliver doula services.

AND

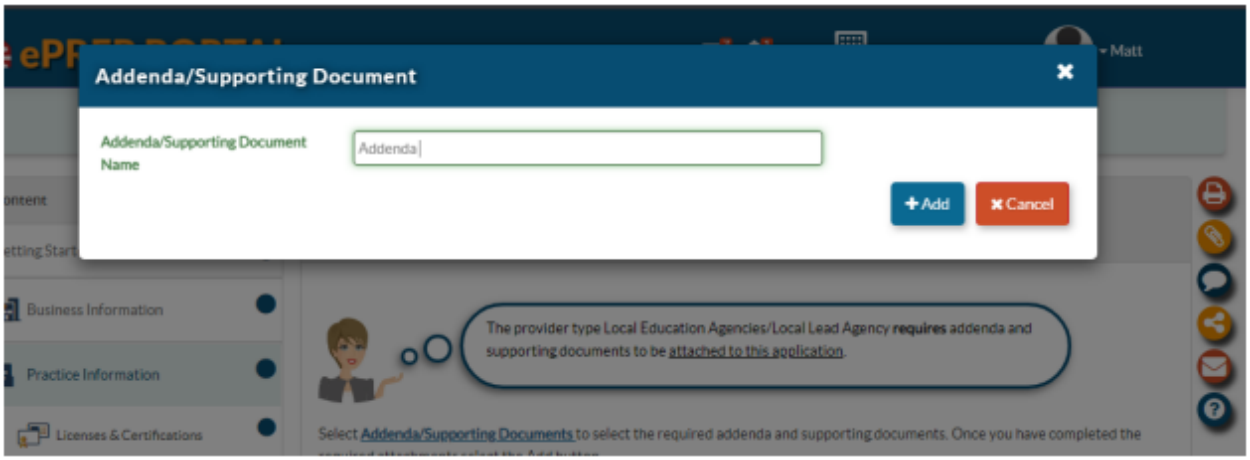
- ❑ The **organization** maintains a typed roster of all doulas who are in good standing, which includes each doula's full name, NPI number (optional), birth date, and Social Security Number; with proof of their qualifications as described above, and will be able to provide supporting documentation if requested by MDH.

Attestation of Liability Insurance [Check one]

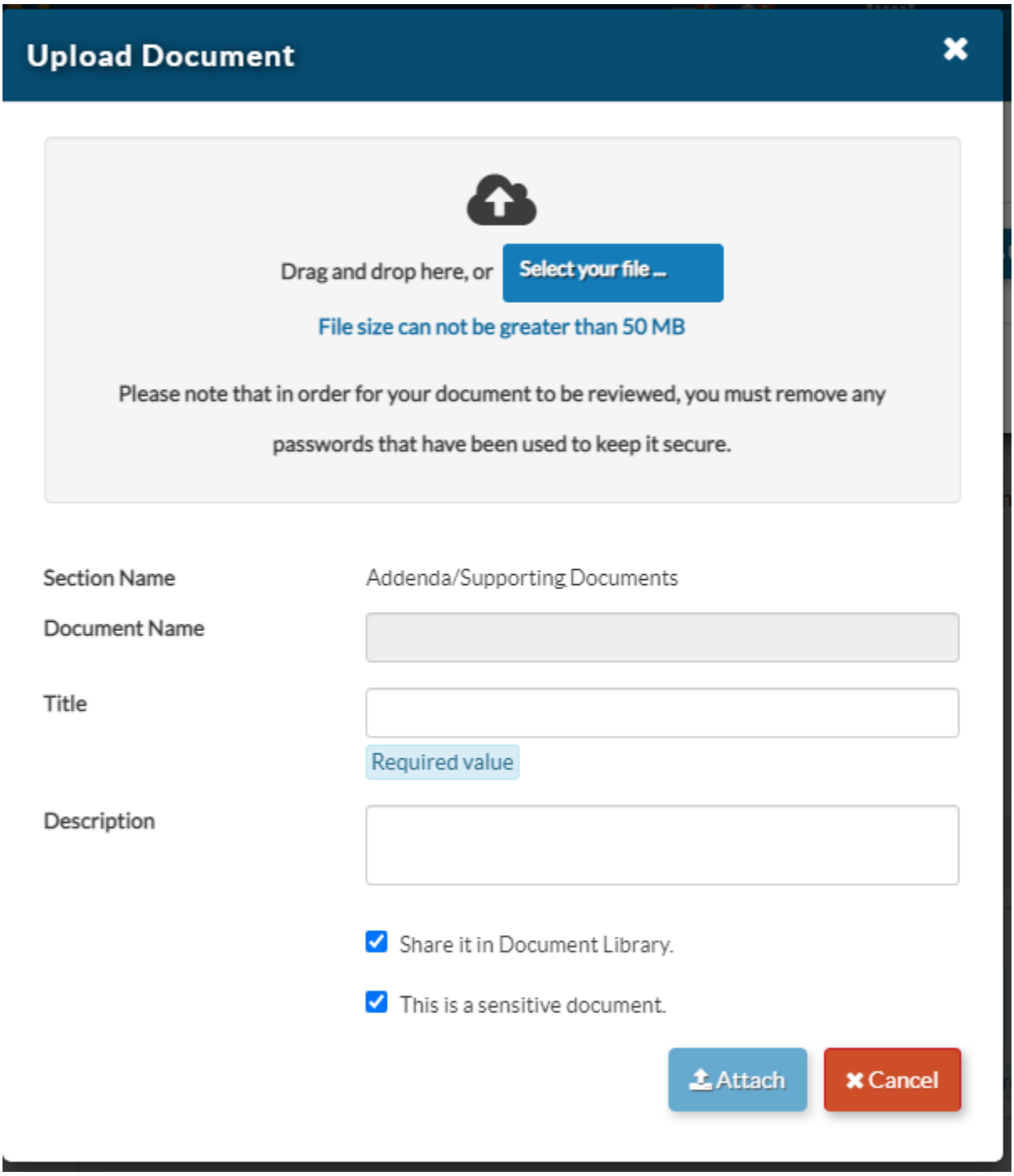
- ❑ Yes, **my organization** requires adequate liability insurance for each doula.
- ❑ No. If no, please attach explanation.

Attestation of Fingerprint Criminal Background Check Completion

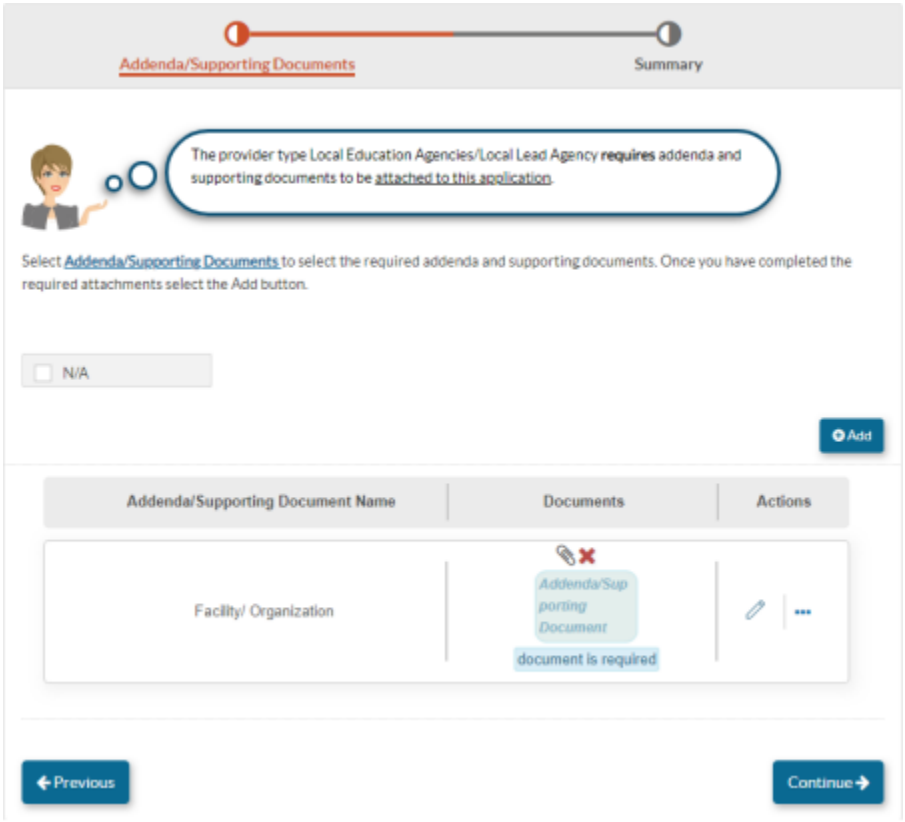
- ❑ I understand that all doula providers have passed a Fingerprint Criminal Background Check (FCBC).



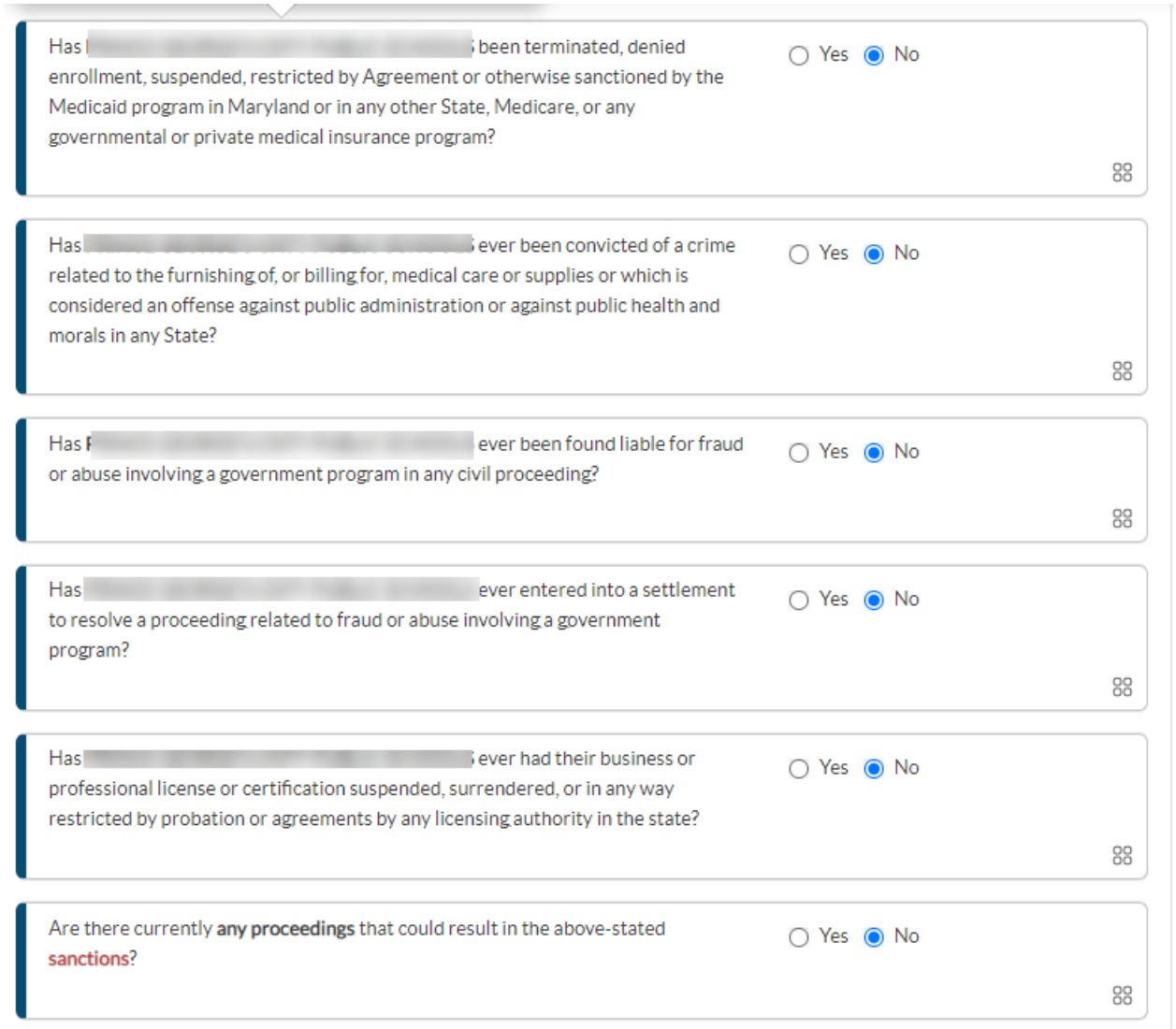
41. Please click on the 'Add' button to name the Addendum.



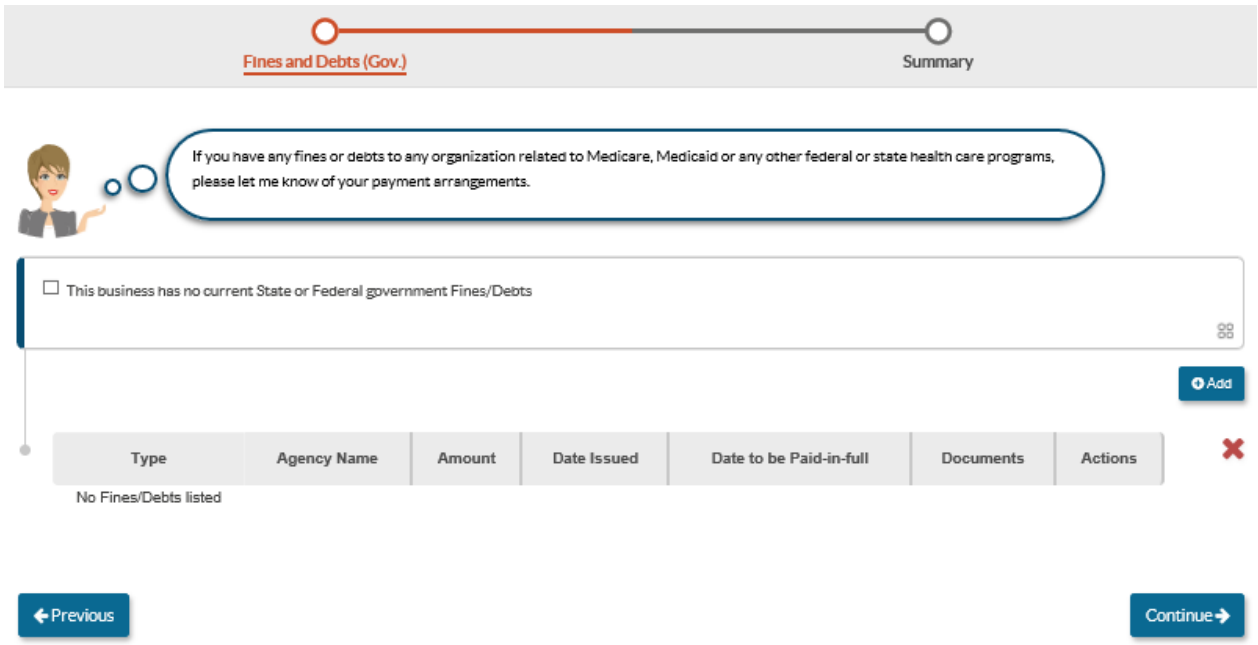
42. Please click ‘Add’ again to upload the Addendum.



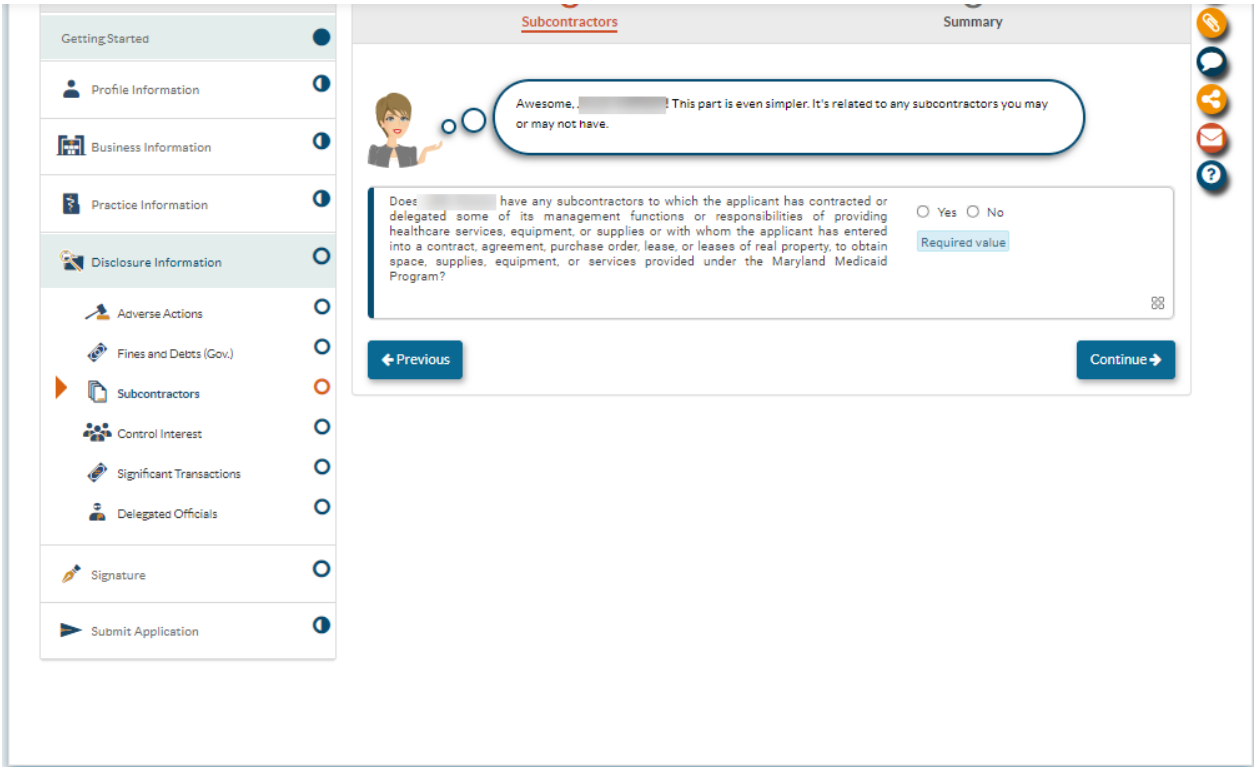
43. Once the Addendum is uploaded, please click continue.

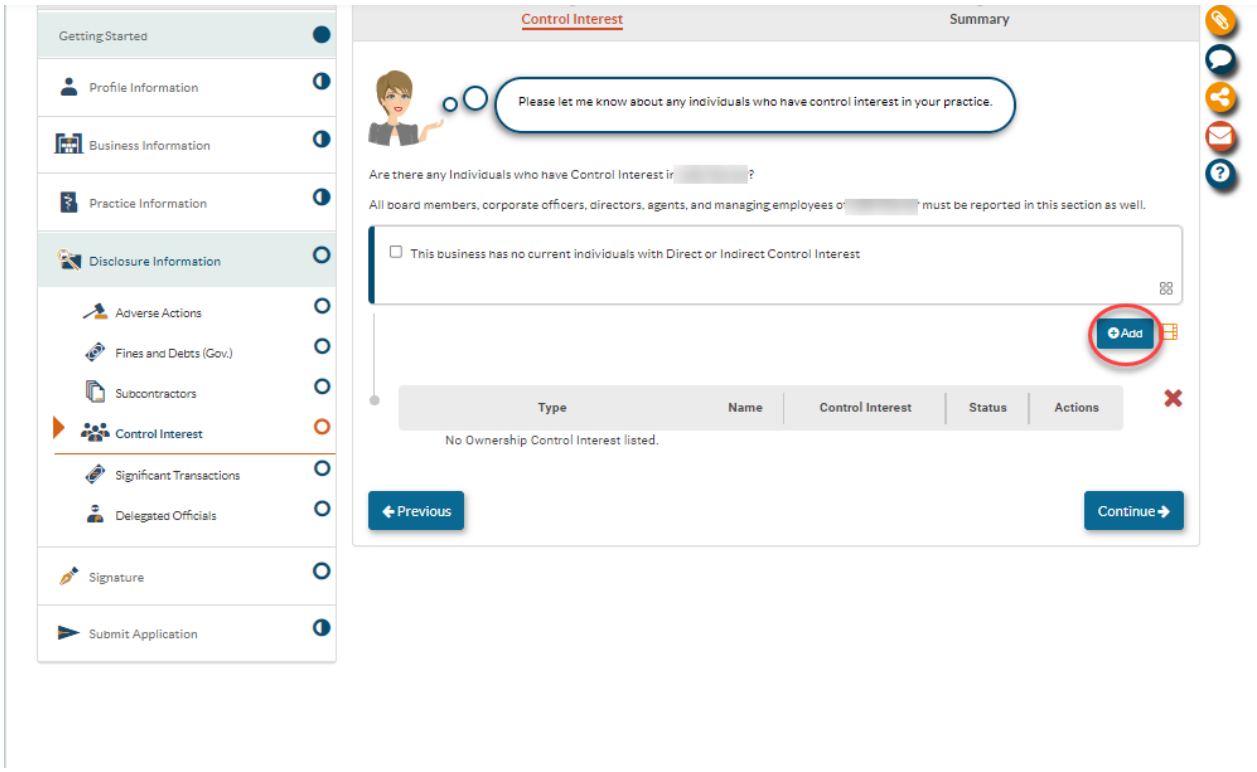


44. This is the 'Adverse Action' page. Please fill out any adverse action information.



45. Once you have completed the adverse action page, please click continue. Please fill out any fines or debts that the organization has.

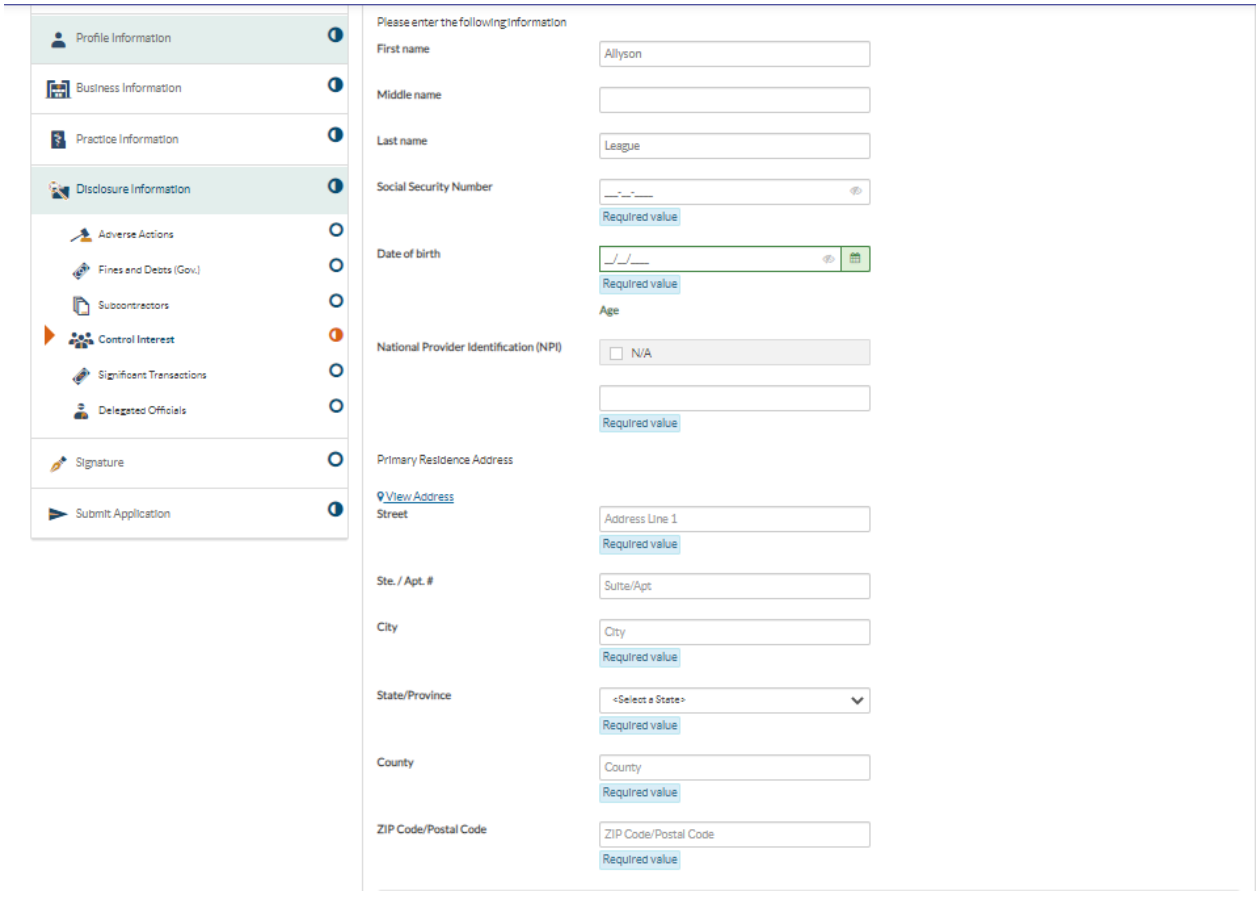


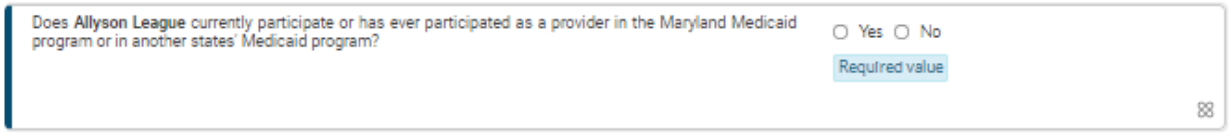


46. This is the Ownership/ Control Interest page. Please click 'Add.' Please enter the provider name and address.

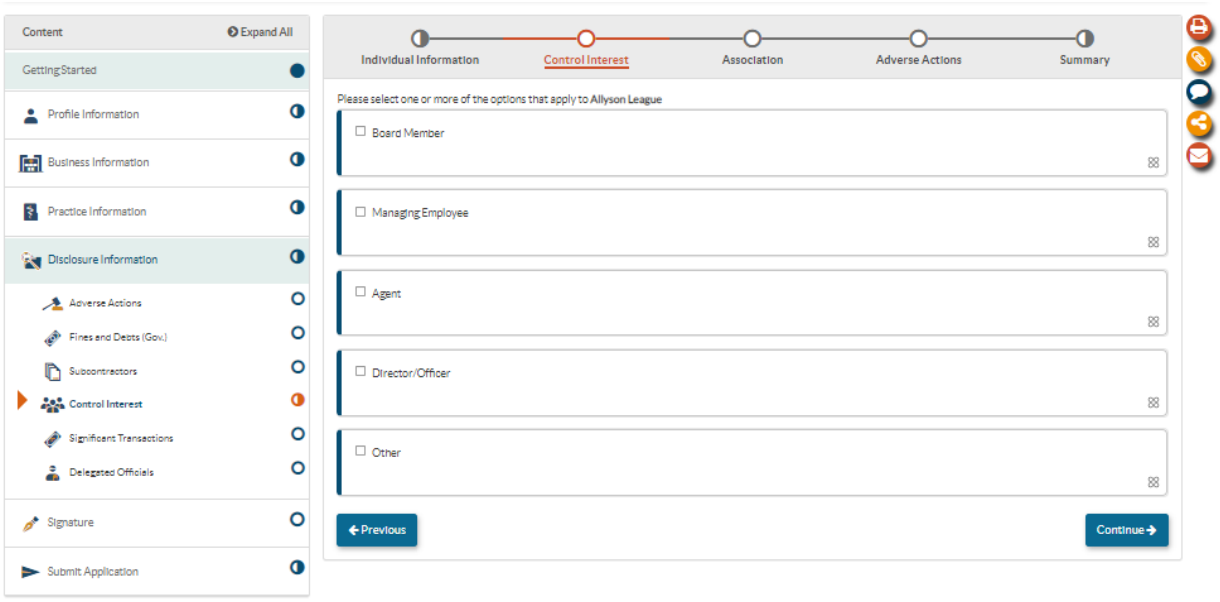
47. Please identify if the organization is owned by an entity or an individual.

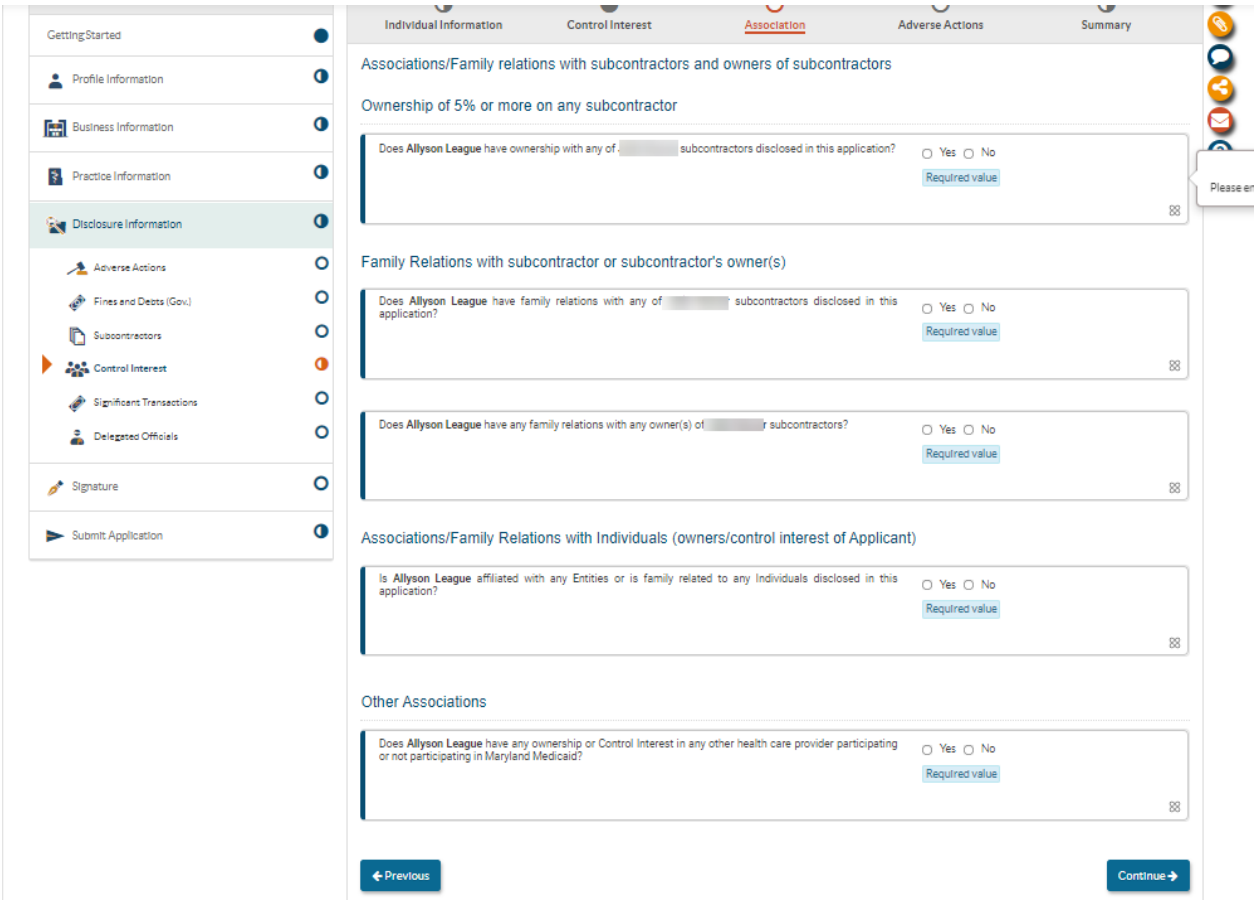
48. With either the entity or individual, please identify their name.



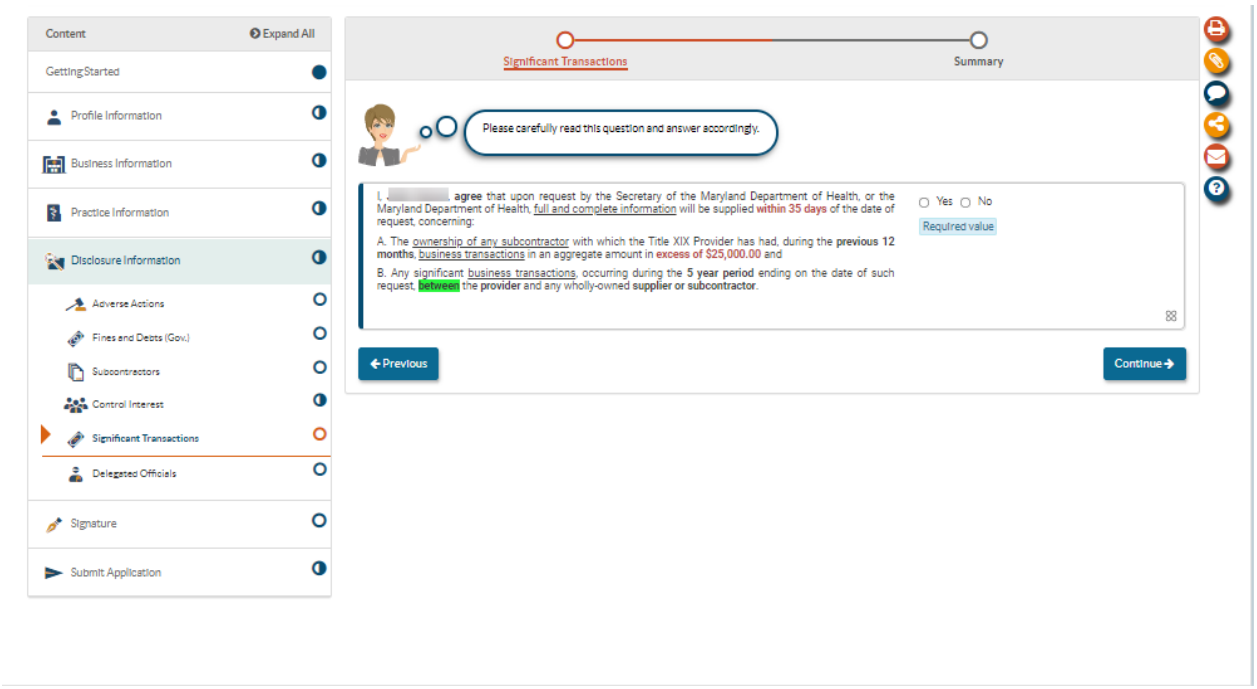


49. Please fill out the ownership individual/entity information.

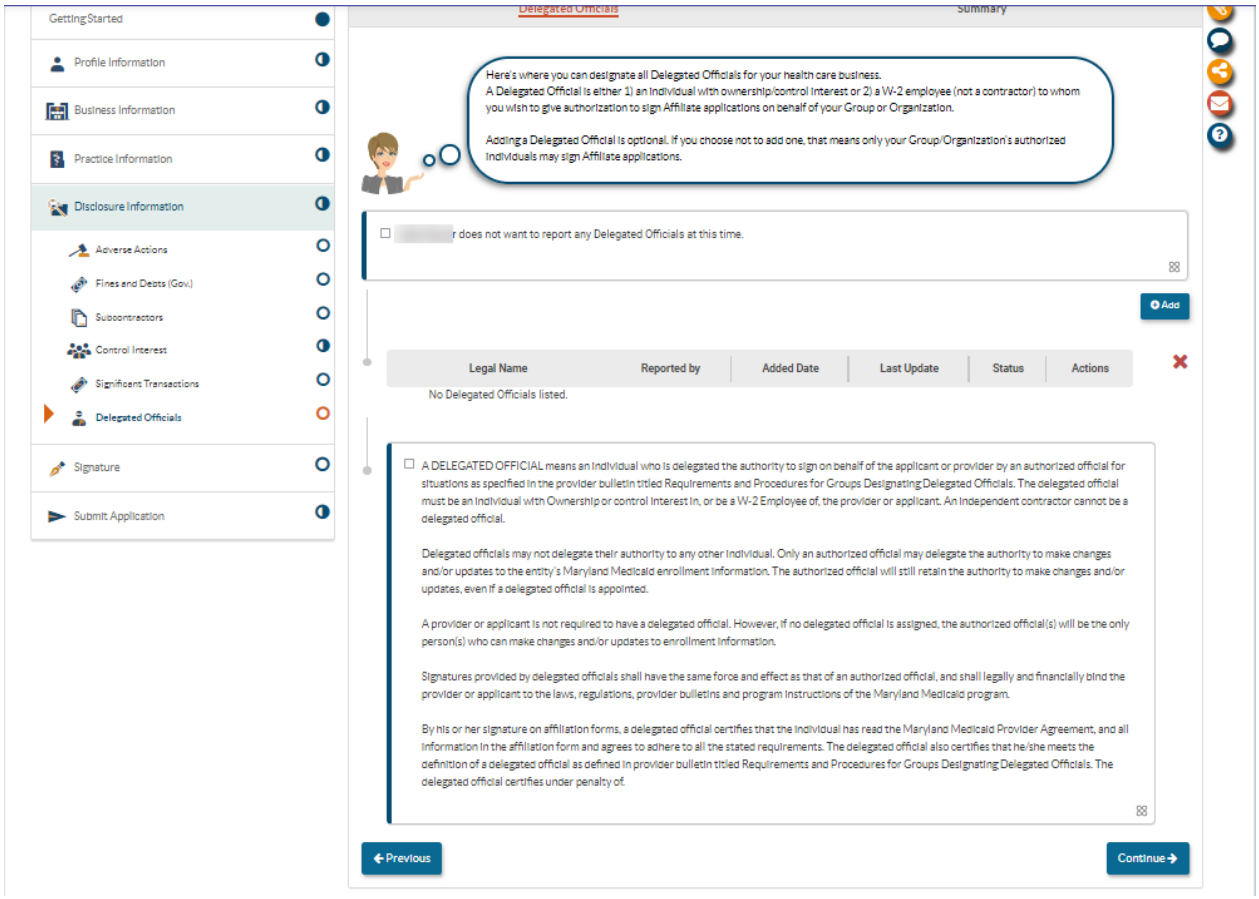




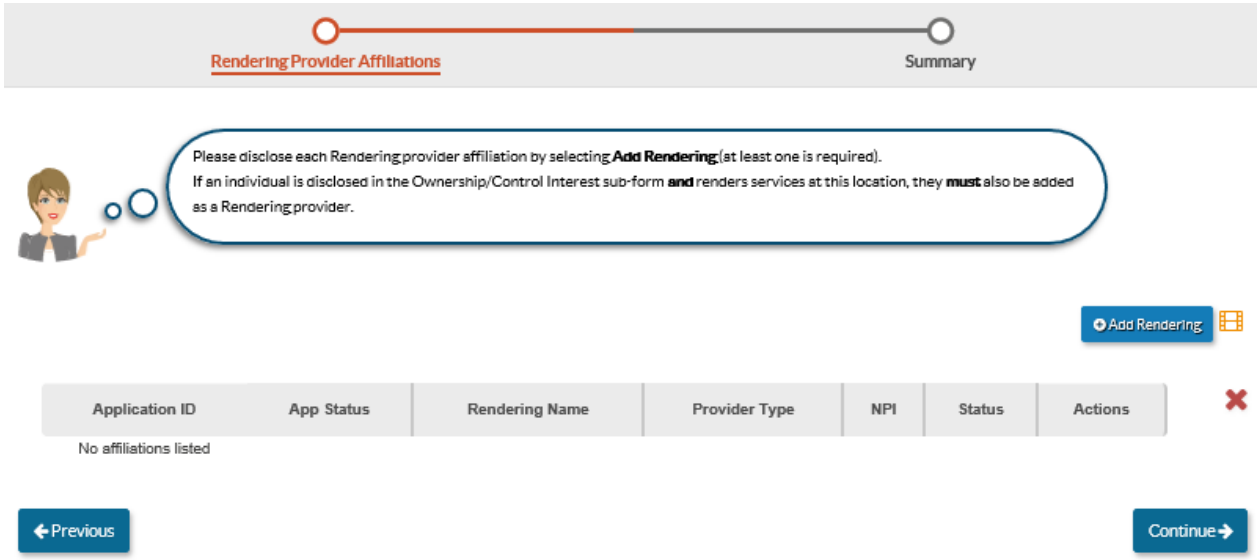
50. Please answer the “yes” or “no” questions about the ownership entity or individual.



51. This is the ‘Significant Transactions’ page. Please mark ‘yes’ to the following question.



52. Please identify any delegated officials.

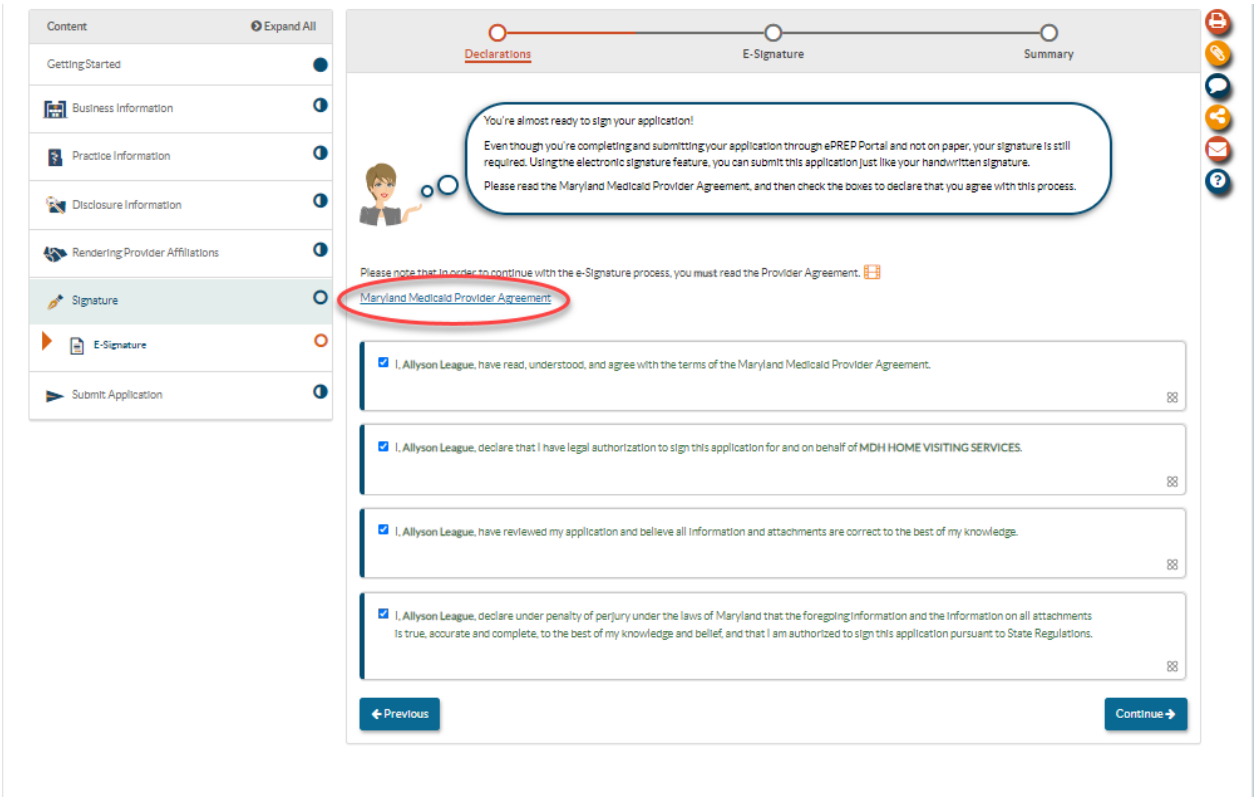


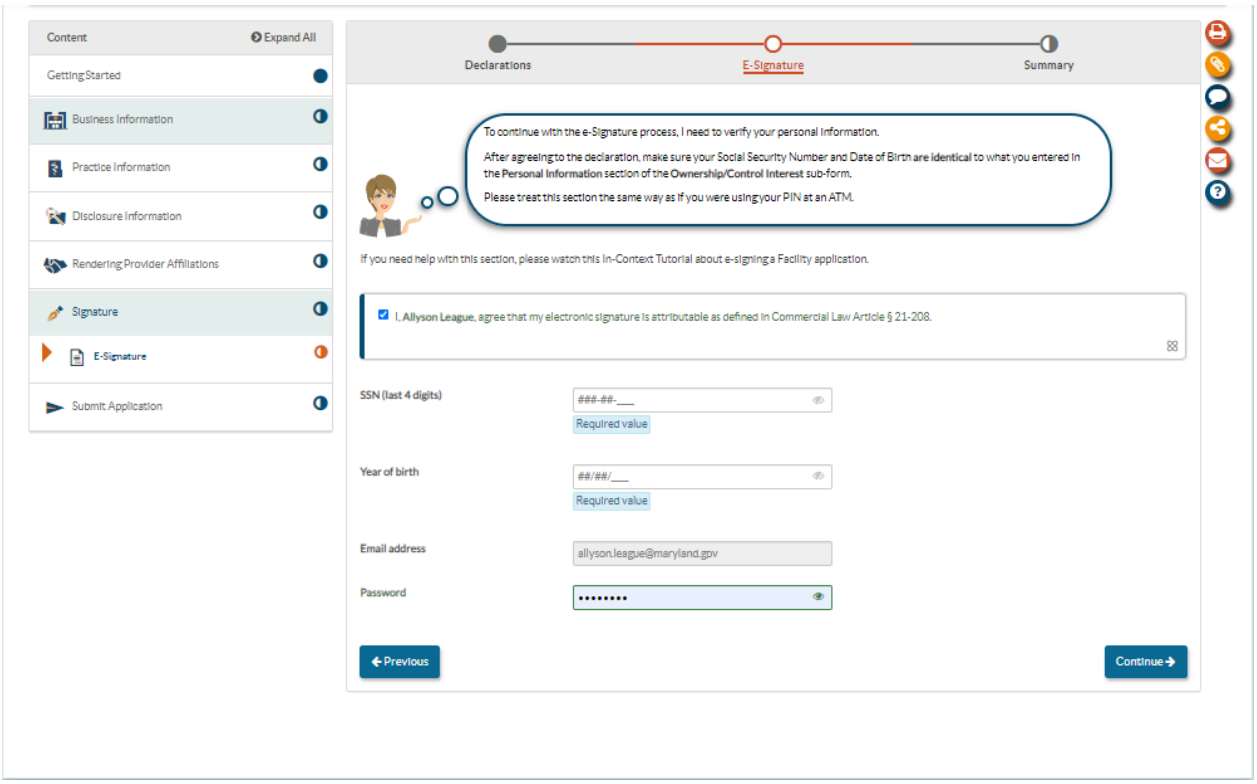
53. Please identify any rendering provider affiliates. If all rendering providers are now affiliated, no action is required. If there are any new rendering providers that need to be affiliated, please do so at this time.

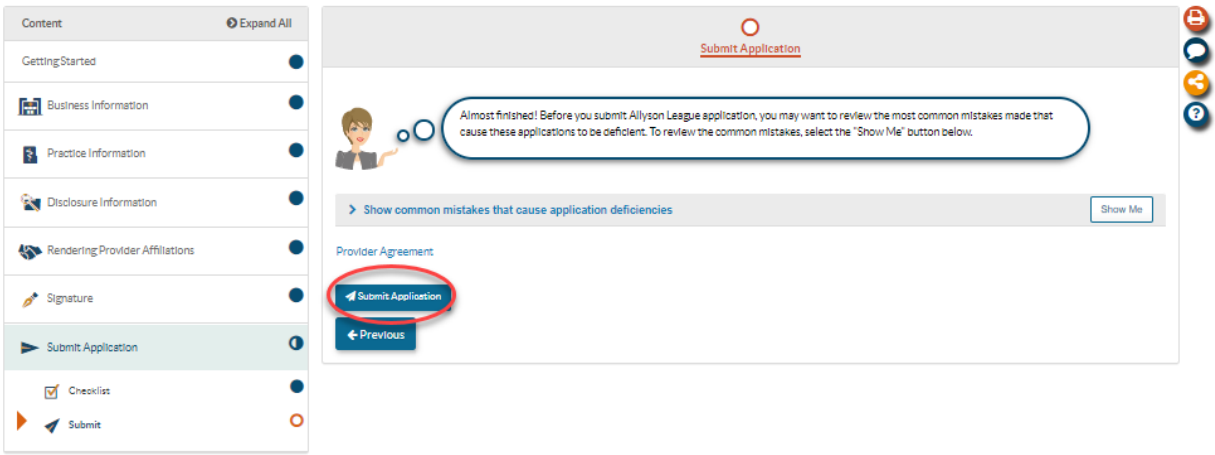
54. If there are no organizational affiliations, please click 'No.'

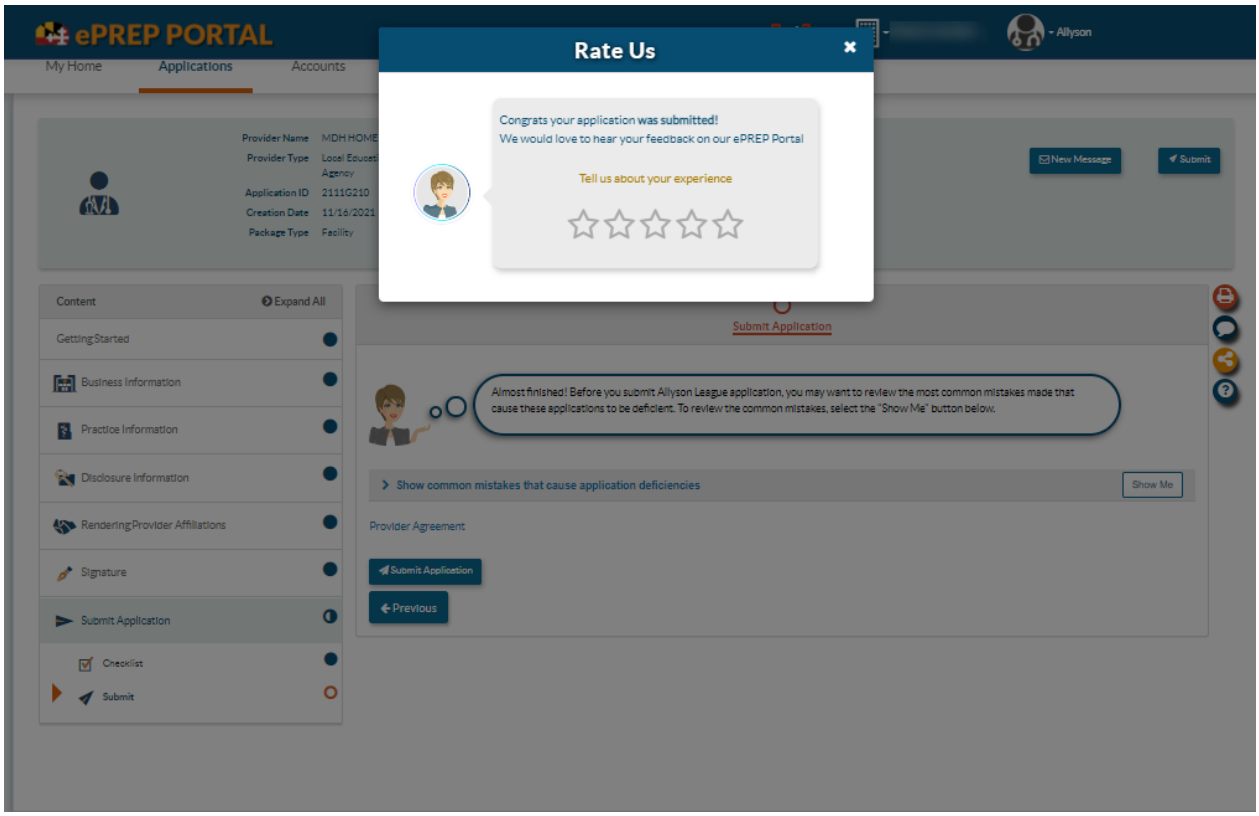
55. If the organization does have affiliations, please click 'Yes' and add any needed information.

56. Once onto the signature portion, please fill out the required information and click submit.




Content
Expand All
Getting Started
Business Information
Practice Information
Disclosure Information
Rendering Provider Affiliations
Signature
E-Signature
Submit Application
Declarations
E-Signature
Summary
To continue with the e-Signature process, I need to verify your personal information.
After agreeing to the declaration, make sure your Social Security Number and Date of Birth are identical to what you entered in the Personal Information section of the Ownership/Control Interest sub-form.
Please treat this section the same way as if you were using your PIN at an ATM.
If you need help with this section, please watch this In-Context Tutorial about e-signing a Facility application.
I, Allyson League, agree that my electronic signature is attributable as defined in Commercial Law Article § 21-208.
SSN (last 4 digits)
###-##-____
Required value
Year of birth
##/##/____
Required value
Email address
allyson.league@maryland.gov
Password
Previous
Continue


Content
Expand All
Getting Started
Business Information
Practice Information
Disclosure Information
Rendering Provider Affiliations
Signature
Submit Application
Checklist
Submit
Submit Application
Almost finished! Before you submit Allyson League application, you may want to review the most common mistakes made that cause these applications to be deficient. To review the common mistakes, select the "Show Me" button below.
Show common mistakes that cause application deficiencies
Show Me
Provider Agreement
Submit Application
Previous



Please feel free to rate the ePREP system and leave any comments that pertain to your application submission.

Thank you for your time.

If you have any questions, please contact us at
mdh.providerenrollment@maryland.gov